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NAVAL POSTGRADUATE SCHOOL

MONTEREY, CALIFORNIA

THESIS

THE BEST APPROACH TO CRISIS INTERVENTION

by

Steven L. Chumley

September 2012

Thesis Advisor:	Fathali Moghaddam
Second Reader:	James Breckenridge

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13. ABSTRACT (maximum 200 words) First responders "protect and serve." They maintain order, prevent chaos, and keep this country safe and secure. Many of the freedoms enjoyed today are the result of U.S. first responders protecting and caring for U.S. citizens. Whether it is a terrorists attack, a criminal victimizing a citizen, or a natural disaster, first responders will be among the first on the scene to deal with the crisis. For this reason, their role in homeland security is so critical. Traumatic stress experienced by first responders may impact their ability to function and handle the next critical incident, as well as obstruct public safety agencies in maintaining a robust and resilient workforce. As a result, leaders of first responder organizations need methods to recognize the different levels of stress their employees are experiencing and identify ways they can support their officers and minimize long-term effects of stress, including absenteeism, early resignation/retirement, depression, post-traumatic stress, substance abuse, and suicide. Critical Incident Stress Management (CISM) is the standard clinical practice most widely utilized by public safety agencies in crisis interventions. CISM is designed to mitigate stress and Post Traumatic Stress Disorder (PTSD). Another technique to help the traumatized, now emerging as a preferred response in crisis interventions, is Psychological First Aid (PFA). The empirical evidence is examined comparing CISM and PFA in an attempt to determine the best care for first responders. Another valuable tool examined, and sometimes overlooked as a crisis intervention tool, is the role of trained chaplains in disaster care. The author has responded to numerous traumatic incidents and witnessed firsthand the effects trauma has on first responders. As a result of witnessing the lack of care CISM provides, he was inspired to research and find the best approach to crisis interventions. PFA and trained chaplains may be the answer; however, the author also desires that this paper inspire and challenge other agencies to invest, conduct further research, and ultimately, find the best approach to crisis interventions.		
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THE BEST APPROACH TO CRISIS INTERVENTION

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Submitted in partial fulfillment of the
requirements for the degree of

**MASTER OF ARTS IN SECURITY STUDIES
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ABSTRACT

First responders "protect and serve." They maintain order, prevent chaos, and keep Americans safe and secure. Much of the freedoms enjoyed today are the result of U.S. first responders protecting and caring for U.S. citizens. Whether it is a terrorists attack, a criminal victimizing a citizen, or a natural disaster, first responders will be among the first on the scene to deal with the crisis. For this reason, their role in homeland security is so critical. Traumatic stress experienced by first responders may impact their ability to function and handle the next critical incident, as well as obstruct public safety agencies in maintaining a robust and resilient workforce. As a result, leaders of first responder organizations need methods to recognize the different levels of stress their employees are experiencing and identify ways they can support their officers and minimize long-term effects of stress, including absenteeism, early resignation/retirement, depression, post-traumatic stress, substance abuse, and suicide.

Critical Incident Stress Management (CISM) is the standard clinical practice most widely utilized by public safety agencies in crisis interventions. CISM is designed to mitigate stress and Post Traumatic Stress Disorder (PTSD). Another technique to help the traumatized, now emerging as a preferred response in crisis interventions, is Psychological First Aid (PFA). The empirical evidence is examined comparing CISM and PFA in an attempt to determine the best care for first responders. Another valuable tool examined, and sometimes overlooked as a crisis intervention tool, is the role of trained chaplains in disaster care.

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PFA and trained chaplains may be the answer; however, the author also desires that this paper inspire and challenge other agencies to invest, conduct further research, and ultimately, find the best approach to crisis interventions.

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LIST OF ACRONYMS AND ABBREVIATIONS

ACLU   American Civil Liberties Union
ACPE   Association of Clinical Pastor Education
ASD   Acute Stress Disorders

CAPPE   Canadian Association for Pastoral Practice and Education
CERT   Community Emergency Response Teams
CHEA   Council on Higher Education Accreditation
CISD   Critical Incident Stress Debriefing
CISM   Critical Incident Stress Management
CPE   Clinical Pastor Education

EMT   Emergency Medical Technician

FEMA   Federal Emergency Management Agency

GERD   Gastro Esophageal Reflux Disease

HIPAA   Health Insurance Portability and Accountability Act

IACET   International Association for Continuing Education
ICISF   International Critical Incident Foundation
ICS   Incident Command Systems

NACC   National Association of Catholic Chaplains
NATO   North Atlantic Treaty Organization
NACCHO   National Association of County and City Health Officials
NCPTSD   National Center for Post Traumatic Stress Disorders
NCTSN   National Child Traumatic Stress Network
NIMH   National Institute of Mental Health
NTSB   National Transportation Safety Board

PCI   Pastor Crisis Intervention Model
PFA   Psychological First Aid
PTSD   Post Traumatic Stress Disorder

RCT   Randomized Controlled Trials

SAIR   Spiritual Aviation Response Team
SAMHSA   Substance Abuse and Mental Health Services Administration

WHO   World Health Organization

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I.   INTRODUCTION

A.   PROBLEM STATEMENT

On April 16, 2007, as a member of the Virginia Department of State Police, the author responded to the Virginia Tech shooting massacre. The scene was horrific and a look of shock was seen on the faces of the first responders and special agents processing the crime scene. Some of the students were in a classroom sitting at their desks when they were brutally gunned down. The faculty at Virginia Tech was also in a state of shock. Not only had they lost students to a crazed gunman but had lost faculty members as well. This tragedy was indescribable. The deaths and suffering of these young adults penetrated the hearts and minds of all who were trying to help. Many could not help but think the unthinkable, could this happen to our children? In the first few hours of the tragedy, the author witnessed chaos. Students on the Virginia Tech campus, not directly involved in the shooting, and later family members of victims, were observed crying and just standing in groups hugging one another near the crime scene. Death and suffering was around everyone. Later that evening, many students and faculty gathered in a candlelight vigil to honor those who had lost their lives.

One of the author's responsibilities at the massacre was to coordinate the Virginia State Police's Chaplain Program. He arrived on the scene and began to assess how many chaplains were needed. First responders and investigators were seeing a horrific scene, and the author knew it would affect them, as it had him. At the scene, 27 students and five faculty members had been killed and 25 students had been wounded. These chaplains would need to provide support for these first responders.

On the first day of the tragedy, the superintendent of the Virginia State Police also assigned the author to provide support for the victims' families, which included delivering death messages to the families, and to coordinate the

response of the state's Critical Incident Stress Management Team (CISM). CISM teams and professional counselors came from all over the nation to help. They were able to provide some support, especially in the weeks that followed, but the author quickly discovered that the chaplains on scene needed the most in the immediate aftermath of the shootings. He witnessed many family members of the victims crying out to God for help. Some families did not know the fate of their loved ones and had a glimmer of hope their loved one may still be alive and were asking for prayer. Many families sought answers to the tragedy and wanted timely updates of the investigation, as well as the identity of the victims at the crime scene. As a first responder and chaplain, the author became a conduit of information, and spiritual support to the victim's family members. Once the victims had been identified by the medical examiner, the author began to meet privately with family members and delivered many of the death messages. He can still hear the death cry of the mothers, fathers, brothers, and sisters.

At this tragedy, relationships were developed between the chaplains and family members of the victims, as well as those first responders involved in the investigation, which occurred primarily due to the training the chaplains received when confronting individuals experiencing grief following a traumatic incident. As Naomi Paget wrote, "Crisis and disaster chaplains are trained in stress mitigation, trauma response, and victim psychology. They are expert listeners and acquainted with grief therapy."[1] Additionally, chaplains realize skills related to ministering in culture and religious diversity, learn to listen to peoples stories, and provide compassionate care. Examples were visible at the Virginia Tech tragedy. The families of victims and first responders represented different cultures and religions. In this tragedy, and many others, the author has been involved in all cultures, religions, and individuals who have no religious beliefs, desire to have someone who will listen to them, accept them, and provide loving

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[1] Naomi Paget, "Impact and Heroic Phases-Large Regional and National Disasters: What Do I Do Now? Congregational and Community Work," in *Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy*, ed. Stephen B. Roberts and Willard W. C. Ashley, Sr. (Woodstock: SkyLights Paths Publishing, 2008), 69–85.

compassionate care. "Being with a human being at the point of suffering is far more significant than words or actions."[2] The chaplains accomplished this caring at Virginia Tech, and as a result, helped mitigate the grief families and first responders were experiencing. The author personally went through this crisis with the many family members of the victims, and the first responders at the scene. He listened, provided compassionate care, and prayed with them.

These activities labored on for more than five days and, as a result, he developed relationships with these families that still live on today. Families and first responders would seek out, talk, express their feelings, and pray with the chaplains because they knew chaplains would help them. A poll taken by Gallup reflects that 97% of Americans believe in God and 90% pray, as a result, it is not surprising that people turn to their faith, spiritual roots, or religious leaders, such as chaplains when experiencing crisis or stress.[3] Chaplains are very much like paramedics who would provide first aid to individuals following an injury. Medics stabilize an injury, provide basic care, and if necessary, call for a higher level of care to take over. The same principles apply to spiritual first aid provided by chaplains: stabilize, assess, provide care and comfort, and refer as necessary.[4]

Unlike the response by these chaplains, CISM teams responded to the Virginia Tech shooting massacre many hours after the attack, and in some cases, days after the attack. The author also coordinated the CISM response to this tragedy and witnessed first responders not communicating with the CISM team members, and believed it was a result of CISM teams not quickly

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[2] Therese M. Becker, Greg Bodin, and Arthur Schmidt, "Impact and Heroic Phases: Disaster Chaplains and Chaplaincy," in *Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy*, ed. Stephen B. Roberts and Willard W. C. Ashley, Sr. (Woodstock: SkyLight Paths Publishing, 2008), 86–105.

[3] Julie Taylor, "Spiritual First Aid," in *Disaster Spiritual Care, Practial Clergy Responses to Community, Regional and National Tragedy*, ed. Stephen B. Roberts and Willard W. C. Ashley, Sr. (Woodstock: SkyLight Paths Publishing, 2008), 106–118.

[4] Ibid., 107.

establishing relationships with those grieving. Additionally, CISM members talked more than they listened. CISM provided good professional guidance but it occurred days after the crisis.

Like first responders who served at the Virginia Tech massacre, most first responders are routinely exposed to traumatic events in the course of their duties. As such, they are at risk for long-term problems identified as PTSD.

While several options to intervene in the lives of those affected with PTSD exist, CISM seems to be the most widely implemented across the United States. CISM is designed to mitigate PTSD in first responders following a traumatic incident.

Although CISM is widely used, research is beginning to demonstrate CISM is harmful and numerous organizations are discontinuing or forbidding the practice. Few studies support the effectiveness of CISM. If CISM is ineffective when provided to first responders and public safety agencies confronting post-traumatic stress, then an alternative approach needs to be considered and researched.

When considering alternatives, one possibility is psychological first aid. "While psychological first aid has not yet been systematically studied, experience in the field suggests that it will be accepted and well received by consumers."[5] This method provides comfort in a social context involving family, friends, co-workers, and chaplains. Public safety agencies typically do not train family and friends for crisis intervention due to the fact the agencies have no control over non-employees; however, public safety agencies can train co-workers and chaplains in crisis intervention.

Training chaplains in crisis intervention would re-enforce the chaplain's usefulness during a traumatic incident. A specially trained chaplain could be a tool in providing psychological first aid to victims, families, and first responders;

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[5] Josef I. Ruzek et al., "Psychological First Aid," *Journal of Mental Health Counseling* (2007): 4.

thus, another alternate consideration to CISM. Chaplains may be overlooked and not utilized because of their association with religion. As a result, governments may refrain from deploying chaplains. The First Amendment to the Constitution states, "Congress shall make no law respecting an establishment of religion, or prohibiting the establishment thereof."[6] In the author's analysis of this document, he cannot see where employing a chaplain would violate this amendment. Chaplains receive training to minister to people associated with any religion, as well as individuals who have no religion. If chaplains are deployed, standardized training is important and chaplains should be "religion neutral." This topic is discussed in more detail later.

The most important aspect to remember is the core component of psychological first aid is providing comfort to first responders following a traumatic incident. Many public safety agencies already utilize chaplains and chaplain services could be easily incorporated into a psychological first aid approach.

B.   RESEARCH QUESTIONS

What is the efficacy of CISM and Psychological First Aid (PFA), according to available empirical evidence? What useful role can chaplains play in providing PFA?

1.   Literature Review

Five sub-literatures provide the theoretical and factual base on which the present research is constructed: Critical Incident Stress Management (CISM), Critical Incident Stress Debriefing (CISD), Post Traumatic Stress Disorder (PTSD), Psychological First AID (PFA), and Disaster Spiritual Care.

The consensus of the literature reviewed is that CISM is the standard clinical practice used in public safety agencies. However, CISM was introduced

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[6] The Declaration of Independence and the Constitution of the United States (U.S. Government Printing Office 2008), 33.

in the 1980s as a powerful, cost-effective approach to crises intervention, and is designed to mitigate PTSD in first responders following a traumatic incident.[7]

Relationships and controversies are identified in the literature. Studies by Dr. Jonathan I. Bisson, Cardiff University, Dr. Bryon E. Bledsoe, University of Nevada School of Medicine, Dr. Stefan Bogaerts, Tilburg University, Dr. Arnold Emmerik, University of Amsterdam, and Dr. Brett T. Litz, Boston University, indicate that CISM interventions do not improve PTSD, and non-CISM interventions improve symptoms of PTSD. Dr. Bledsoe, Dr. Litz, Dr. Richard J. McNally, Department of Psychology, Harvard University, and Dr. Josef I. Ruzek, National Center for PTSD, believe CISM can do more harm than good to individuals experiencing PTSD. Dr. Bisson, Dr. Bledsoe, Dr. Litz, and Dr. Matt J. Gray, Director of Clinical Training, University of Wyoming, also recommend CISM be discontinued. Dr. Suzanna Rose, Florida International University, claims CISM may have negative effects.[8]

On the other hand, Dr. George S. Everly, Jr., John Hopkins School of Public Health, Co-founder of the Critical Incident Stress Foundation, and Dr. Jeffery T. Mitchell, University of Maryland, President of International Critical Incident Stress Foundation, identify CISM as a good practice.[9] Dr. Everly and Dr. Mitchell's assertion may be considered biased since he developed CISM to mitigate PTSD. Dr. Atle Dyregrov, Director of Centre for Crisis Psychology, Bergen Norway, claims psychological debriefings accelerate the recovery of normal people, but the definition of normal people is overlooked.[10]

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[7] George S. Everly, Jr. and Jeffrey T. Mitchell, "A Primer on Critical Incident Stress Management (CSIM)," *The International Critical Incident Stress Foundation* (n.d.). 2, http://www.icisf.org/who-we-are/what-is-cism.

[8] Suzanna Rose and Jonathan Bisson, "Brief Early Psychological Interventions Following Trauma: A Systematic Review of Literature," *Journal of Traumatic Stress* 11, no. 4 (1998): 697–710

[9] Everly and Mitchell, "A Primer on Critical Incident Stress Management (CSIM)," 2.

[10] Atle Dyregrov, "Caring for Helpers in Disaster Situations: Psychological Debriefing," *Disaster Management* 2, no. 1 (1989): 25–30.

Controversies are also identified in the literature. Dr. Roger F. Peters, retired psychologist, describes the meta-analysis conducted by Dr. Rose on CISM's ineffectiveness to be in conflict with the meta-analysis conducted by Dr. Everly and Dr. Mitchell. Dr. Peters also proposes the Rose research is flawed due to studies drawn from desperate groups, not emergency service workers.[11] Dr. Bledsoe reports CISM studies were anecdotal and of poor scientific quality; however, the studies on the ineffectiveness of CISM are more reliable.[12] Dr. Peters also claims the meta-analysis performed by the proponents of CISM is flawed and criticized by mainstream psychologists.[13] Dr. Everly and Dr. Mitchell claim CISM programs are empirically validated through qualitative analysis, controlled investigations, and meta-analysis. Additionally, Dr. Everly and Dr. Mitchell claim no evidence exists to prove CISM is harmful.[14]

Methodologies include the studies of single session debriefings conducted in group or individual settings. Review of studies, articles, books, literature reviews, and randomized controlled trials (RCTs) were examined.

Dr. Bisson focuses on individuals exposed to traumatic events (one month or less). Dr. Bisson examines 15 random controlled trials, and records poor results in CISD efficacy.[15] Six trials are not in the analysis. Dr. Emmerik examines seven studies that include five CISM interventions, three non-CISM interventions, and six with no intervention controls.[16] Dr. Bogaerts reviews a sample of three groups of security workers that include 68 individuals directly

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[11] Roger F. Peters, "CISD's: Continuing Problems," 2007, http://www.heas.com.au/publications/cisd.htm.

[12] Bryan E. Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," December 1, 2003, http://www.emsworld.com/print/EMS-World/EMS-Myth-3--Critical-Incident-Stress-Management-CISM-is-effective-in-managing-EMS-related-stress/1$2026.

[13] Peters, "CISD's: Continuing Problems."

[14] Everly and Mitchell, "A Primer on Critical Incident Stress Management (CSIM)."

[15] Suzanna Rose et al., *Psychological Debriefing for Preventing Post Traumatic Stress Disorder (PTSD) (Review)* (The Cochrane Library, John Wiley & Sons, Ltd., 2009).

[16] Arnold A. P. van Emmerik et al., *Single Session Debriefing After Psycological Trauma: A Meta Analysis* (Amsterdam: Department of Clinical Psychology, University of Amsterdam, 2002).

exposed to a traumatic incident, 67 individuals indirectly exposed to a traumatic incident, and 77 individuals who had not experienced a traumatic incident in the last six months.[17]

Another study conducted by Dr. Gray argues that the majority of first responders experiencing a traumatic incident will not develop PTSD, and that CISD is not intended for victims of trauma, which is often incorporated into the research. Dr. Gray reports that only a few randomized control trials have been completed and his key assumption is that a lack of random assignments and no intervention comparison groups are essential for evaluating CISM's effectiveness.[18] Gaps in the literature reported by Dr. Ruezk and Dr. Michelle R. Tuckey, Senior Lecturer, University of South Australia, reflect that much of the research overlooks high-risk health behaviors, age, trauma history, and available social support to first responders exposed to traumatic incidents. Dr. Tuckey identifies the research conducted as controlled, not randomized, and that the methodology of CISM paints a confusing picture.[19]

Other gaps were discovered in the literature. Dr. Gray portrays CISD as being performed by both professionals and non-professionals. The level of training provided to CISD providers was not articulated or performed in a standardized manner.[20]

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[17] Stefan Bogaerts et al., "Critical Incident, Adult Attachment Style, and Posttraumatic Stress Disorder: A Comparison of Three Groups of Security Workers," *Social Behavior and Personality* 36, no. 8 (2008): 1063–1072.

[18] Matt J. Gray, Shira Maguen, and Brett T. Litz, "Acute Psychological Impact of Disaster and Large-Scale Trauma: Limitations of Traditional Interventions and Future Practice Recommendations," *Prehospital and Disaster Medicine* 19, no. 1 (2004): 64–72.

[19] Michelle R. Tuckey, *Issues in the Debriefing Debate for the Emergency Services: Moving Research Outcomes Forward* (Blackwell Publishing, 2007).

[20] Gray, Shira, and Litz, "Acute Psychological Impact of Disaster and Large-Scale Trauma: Limitations of Traditional Interventions and Future Practice Recommendations," 64–72.

Another discovery was that when early intervention occurred, PTSD was mitigated. The literature suggests that early intervention is critical in helping individuals cope with a traumatic incident. The problem discovered was that most agencies allowed the time of intervention to vary from a few days to several months. The time lapses were not helpful to first responders.

The methodologies of the studies are not consistent, and overall, CISM is portrayed as a negative technique to first responders. All studies conducted on the role of CISM suggest more research is needed on CISM's effectiveness.

Research is beginning to provide alternatives to CISM to include, psychological first aid. Dr. Bledsoe, Dr. Litz, Dr. Ruzek, and the World Health Organization (WHO) recommend utilizing psychological first aid. Dr. McNally recommends psychological first aid if researched and proven to be useful. "While psychological first aid has not yet been systematically studied, experience in the field suggests that it will be acceptable to and well received by consumers."[21] The literature on psychological first aid suggests research is needed on its effectiveness.

Dr. Mitchell claims CISM is a form of first aid.[22] Also discovered in this research is the importance of providing comfort in a social context through family, friends, co-workers, and clergy. Dr. Ruzek identifies providers of psychological first aid as mature individuals, medical professionals, school personnel, and members of the clergy.[23]

A voluminous amount of literature and historical evidence relevant to the role of chaplains does exist. Historically, spiritual care has been present since the dawn of civilization. In the 1920s, Anton Boisen recognized the need for spiritual care and is highly regarded as a pioneering figure in hospital chaplaincy and

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[21] Ruzek et al., "Psychological First Aid," 4.

[22] Everly and Mitchell, "A Primer on Critical Incident Stress Management (CISM)," 2.

[23] Ruzek et al., "Psychological First Aid," 4.

clinical pastoral education.[24] Military chaplains have a history of serving beside soldiers and going into harm's way with them.[25] In 1996, Congress passed The Aviation Disaster Family Act to improve support for family members after an aviation crash. Through the Red Cross, and the Association of Professional Chaplains, a spiritual support team encompassing chaplains was developed and is now used at all aviation disasters for family members of victims and first responders.[26] Over 900 of these members were deployed following the terrorist attack on 9/11.[27]

A theme present in literature on the utilization of chaplains is that best practices for spiritual care need to be developed. For example, in "The Trauma of Terrorism: Religious Care in Coping with Terrorism,"[28] a chaplain's function is articulated as a spiritual support and comforter for a broad number of individuals representing many faith traditions and cultures. At a mass causality incident, many faiths and denominations are represented and some have no religious beliefs at all. As a result, chaplains are trained not to preach or proselytize their own specific faith tradition, but instead, to be a good listener.[29]

The literature has identified the following appropriate spiritual care interventions by chaplains.

- Listen more than you speak
- Encourage people to tell their stories
- Refrain from imposing an explanation as to "why"
- Connect people with personal support community
- "Communized" intrusive thoughts and feelings

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[24] Becker, Bodin, and Schmidt, "Impact and Heroic Phases: Disaster Chaplains and Chaplaincy," 86–105.

[25] Ibid., 100.

[26] Ibid.

[27] Zahara Davidowitz-Farkas and John Hutchison-Hall, "Religious Care in Coping with Terrorism," in *The Trauma of Terrorism*, ed. Yael Danieli, Danny Brom and Joe Sills (Binghamton: The Haworth Maltreatment & Trauma Press, 2005), 565–576.

[28] Ibid., 573

[29] Ibid.

- Help the individual accept reality of the loss

- Allow individuals to share stories of their loved ones

- Offer hope

- Do not be afraid to weep with those who weep

- Acknowledge individual's/family's grief

- Provide sacred space

- Facilitate appropriate rituals

- Pray with/for them

- Respect confidentially

- Avoid clichés

- Suggest other support services, such as mental health, as needed

- Do not attempt to solve problems, but support them in coming up with their own answers[30]

Social contacts, such as friends, co-workers, and clergy or chaplains, are a critical component in delivering psychological first aid. Psychological first aid incorporates a response to a traumatic incident within minutes or hours and is portrayed in the research as more effective, because psychological first aid providers are at the scene and earn the right to speak with first responders. As articulated in all the literature, timely intervention can be instrumental in a first responder's ability to process and quickly recover from a traumatic event.

Psychological first aid can involve the incorporation of religious coping behaviors, and chaplains are in the perfect position to accommodate that role. Research provides some statistics into the successes of counseling individuals suffering from posttraumatic stress utilizing religious coping behaviors. In the *Journal of Nervous and Mental Disease*, authors conclude that religious coping behaviors relate better to mental health than non-religious coping behaviors.[31]

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[30] Becker, Bodin, and Schmidt, "Impact and Heroic Phases: Disaster Chaplains and Chaplaincy," 86–105.

[31] Rich Deem, "Scientific Studies That Show a Positive Effect of Religion on Health," *Evidence for God*, May 19, 2006, http://www.godandscience.org/apologetics/religionhealth.html, 3.

Also in the *Journal of Consulting and Clinical Psychology*, religious therapy results in significantly faster recovery from depression when compared with standard behavioral therapy.[32]

The American Red Cross conducted a national poll one month following the 9/11 terrorist attacks. Results showed approximately 60% of all respondents said they would likely seek help from a spiritual counselor, compared to 45% of all respondents who would seek help from a physician and 40% who would seek help from a mental health care professional.[33] Statistics claim 97% of Americans believe in God and 90% pray. As a result, it is not surprising that people turn to their faith or spiritual roots when experiencing crisis or stress.[34]

Considering the literature reviewed and the author's personal experience as a first responder and a chaplain, it is obvious the current traumatic response practices are flawed. Individually, CISM is an ineffective tool due primarily to training levels and response times. CISM members, as well as chaplains, may not be trained at the same levels, which lead to inconsistencies in the debriefing process. Delays in response times can vary up to several months after a critical incident has occurred and these delays are unacceptable since the main focus should be a near to immediate response. In addition to inadequate training and lagging response times, CISM's approach to a group environment is not always conducive for the traumatized. This approach allows no room for confidentiality or personalized healing.

First responders are often confronted up close with death and their own mortality. They begin to ask questions ranging from life and death, to sin and forgiveness. A chaplain is able to discuss these matters without judgment and with confidentiality. Some research conducted provides a glimpse into the successes of chaplains utilizing religious coping behaviors. In a report submitted

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[32] Deem, "Scientific Studies That Show a Positive Effect of Religion on Health," 3.

[33] Davidowitz-Farkas and Hutchison-Hall, "Religious Care in Coping with Terrorism," 565–576.

[34] Taylor, "Spiritual First Aid," 106–118.

to the U.S. Department of Justice on East Lansing Police's Chaplain Program, a survey revealed 82% of employees would seek out the services of a chaplain when confronting stress.[35] Additionally, East Lansing Police Chaplains believe "our officers will be more likely to respond to a police chaplain whom they have been acquainted with, than seeking out a mental health consultant whom they do not know and may not trust."[36]

An alternative approach should be considered. Although little research or randomized clinical trials have been conducted in the area of psychological first aid, providing evidence and measuring the impact of survivor adaption and functioning could gauge the effectiveness of psychological first aid following a traumatic event.[37] A traumatic response team could incorporate other facets of the mitigation process, and comprise a traumatic response team of trained psychological first aid providers to include fully trained chaplains trained in disaster spiritual care to enable a team to personalize the coping process. This team will be capable of assisting the traumatized in varying degrees and the addition of the chaplain providing psychological first aid will enable healing on a religious and a non-religious level.

2.   Crisis Management Unified Response Team

A unified response team may include decision makers of public safety agencies, trained PFA providers, trained chaplains in disaster care, and mental health experts. This team could develop a template that would enable federal, state, local, and tribal leaders to prepare for, respond to, and help mitigate psychological trauma effectively and efficiently. Terminology, procedures, roles, duties, and responsibilities can be clarified and standardized to improve

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[35] East Lansing Police Department, East Lansing Police Chaplain's Program, Document No. 186050, U.S. Department of Justice, 2000, 5.

[36] Ibid., 12.

[37] Ruzek et al., "Psychological First Aid," 10.

coordination and interagency cooperation. A crisis management unified response team may prove to be an invaluable tool for all types of traumatic incidents, since all levels of trauma can be addressed with a one-team approach.

C.   PLACEBO EFFECT

The placebo effect refers to a phenomenon, a fake treatment or an inactive substance, that can improve an individual's condition simply because of the belief that the treatment will be beneficial. The more a person believes a treatment will be helpful, the more likely a person will experience a benefit.[38] The placebo effect is also the measureable, observable, or felt improvement in health not attributable to an actual treatment.[39]

Research on the placebo effect focuses on the relationship between the mind and body. A common theory is that the placebo effect is due to a person's expectations. For example, if a person expects a pill to do something, then it is possible that the body's own chemistry can cause effects similar to what a medication might have caused.[40] The placebo effect is part of the human potential to react positively to a healer.[41] A familiar example in this concept is seen when a Band-Aid is placed on a child. It often makes the child feel better even though no medical reason exists that it should make the child feel better.[42]

In a study published by the *American Journal of Psychiatry*, it is suggested that patients with major depression who receive placebos experience changes in

[38] MedicineNet.com. *Definition of Placebo Effect.* June 14, 2012. http://www.medterms.com/script/main/art.asp?articlekey=31481, 1.

[39] Kendra Cherry, "What Is the Placebo Effect?" *About.Com Psychology,* (n.d.), http://psychology.about.com/od/pindex/f/placebo-effect.htm, 1.

[40] WebMD, Pain Management Health Center, "What Is the Placebo Effect?" January 31, 2012, http://www.webmd.com/pain-management/what-is-the-placebo-effect, 1.

[41] MedicineNet.com, "Definition of Placebo Effect," June 14, 2012, http://www.medterms.com/script/main/art.asp?articlekey=31481, 2.

[42] Ibid.

brain function similar to changes caused by medication.[43] A possible explanation of this phenomenon is discovered in studies of brain scans in which patients believe a taken placebo drug reduces pain. The placebo then triggers a release of endorphins. Endorphins have been identified to have a structure similar to morphine and other opiate painkillers that act as the brain's own natural painkillers.[44] Conversely, individuals who experience negative symptoms from a placebo are referred to as a "nocebo effect." An example of the nocebo effect could be headaches, nausea, or dizziness.[45]

Furthermore, in a study by Irving Kirsch and Guy Sapirstein, "Listening to Prozac but Hearing Placebo" a meta-analysis of antidepressants was given to 2,318 patients who had been randomly assigned to either antidepressant medication or placebo in 19 double-blind clinical trials.

> As a proportion of the drug response, the placebo response was constant across different types of medication (75%), and the correlation between placebo effect and drug effect was .90. This data indicates that virtually all of the variation in drug effect size was due to the placebo characteristics of the studies. The effect size for active medications that are not regarded to be antidepressants was as large as that for those classified as antidepressants, and in both cases, the inactive placebos produced improvement that was 75% of the effect of the active drug.[46]

Table 1 shows the placebo response was proportionate to the drug response, with remaining variability most likely due to measurement error.

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[43] Melinda T. Willis, "Study: Placebo Alters Brain Function," *ABC News*, (n.d.), http://abcnews.go.com/Health/Depression/story?id=117057&page=1#.UAIcglss684, 2.

[44] Cherry, "What is the Placebo Effect?", 1.

[45] Ibid., 2.

[46] Irving Kirsch and Guy Sapirstein, "Listening to Prozac but Hearing Placebo: A Meta-Analysis of Antidepressant Medication," *Prevention & Treatment* 1, no. 2 (1998): 1–16.
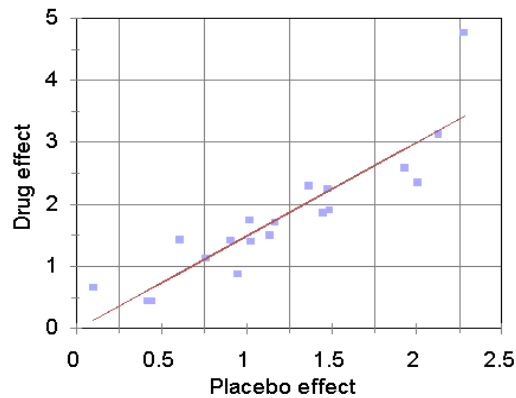
Table 1.   Placebo Response[47]

"Just as drug effects can be estimated as the drug response minus the placebo response, placebo effects can be estimated as the placebo response minus the no-treatment response. This data indicates that approximately one quarter of the drug response is due to the administration of an active medication, one half is a placebo effect, and the remaining quarter is due to other nonspecific factors"[48] (Figure 1).
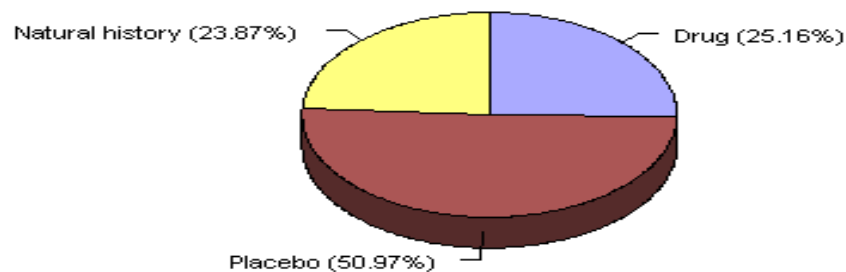
Figure 1.   Drug Effect, Placebo Effect, and Natural History.[49]

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[47] Kirsch and Sapirstein, "Listening to Prozac but Hearing Placebo: A Meta-Analysis of Antidepressant Medication," 6.

[48] Ibid., 11.

[49] Ibid.

In the analysis of the placebo effect, an individual's expectations are central to the healing process. Additionally, a doctor or caregiver does more by their presence with the patient and family than anything else.[50] For example, a sub-conscious association of seeing a doctor in a white coat can control bodily processes, such as immune responses and the release of hormones.[51] Through the visualization of the patient seeing the doctor, the patient knows that help has arrived.

What is the relevance of the placebo effect in crisis interventions? From a positive and a negative viewpoint, the placebo effect is applicable to all crisis intervention methods. From a positive viewpoint, the visualization or presence of a crisis management team, or a trained individual in crisis intervention, may help the victim through a traumatic event. Victims of trauma often believe that if someone cares, coping mechanisms will be provided, and thus, mitigate the stress being experienced. Just knowing someone is concerned and available to help can make a positive impact on the recovery process. Centuries ago, Hippocrates wrote, "some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician."[52] Likewise, members of a crisis management team have good intentions. Most victims know this, realize that the provider cares about their welfare, and will provide help or services to overcome their trauma.

In contrast, the placebo effect, known as the nocebo effect, is relevant because the visualization of a crisis management team may induce negative feelings from the victim. The victim may recall a crisis intervention that did not work well or remember a previous provider just going through a "canned

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[50] Franklin G. Miller, "Williams James, Faith, And The Placebo Effect." *Perspectives in Biology and Medicine* (2005): 274.

[51] Maj-Britt Niemi, "Placebo Effect: A Cure in the Mind (Preview)," *Scientific American,* February 25, 2009, http://www.scientificamerican.com/article.cfm?id=placebo-effect-a-cu, 2.

[52] Jozien M. Bensing and William Verheul, "The Silent Healer:The Role of Communication in Placebo Effects," *Patient Education and Counseling* (2010): 293–299.

presentation" on how to cope with a traumatic event. In this case, the victim may decide that no help will be received before any help is offered. Stress from this reaction is not mitigated and may even become worse for the victim.

Understanding the placebo effect, or nocebo effect, can help in the delivery of a crisis intervention technique, and thus, make it important when considering the best approach to crisis interventions. Any crisis intervention method is only as good as the individual delivering it, which underscores the importance of a crisis intervention provider possessing the right attitude. Additionally, a provider needs to understand the intended audience by listening and looking for any bias, positive or negative that may induce a placebo effect when trying to help someone. This understanding can be accomplished by looking at a victim's reactions and listening through verbal and non-verbal communications.

D.   PRACTICAL SIGNIFICANCE OF POLICY ANALYSIS

First responders respond daily to traumatic events. They are on the front lines following a terrorist attack or traumatic incident. They see death, pain and suffering on a large scale. As such, they are at risk of developing PTSD. First responders experiencing PTSD may disrupt public safety agencies responsible for homeland security due to lost time from work, increased health care costs, and a less resilient work force capable and ready to respond to the next incident.

Dr. Fathali M. Moghaddam and Dr. James N. Breckenridge, in "The Post-Tragedy Opportunity-bubble and the Prospect of Citizen Engagement," identify an opportunity bubble, "a promising, yet fleeting opportunity to shape the course of subsequent events."[53] Following a traumatic event, or terrorist attack, PTSD is mitigated when timely intervention can be provided. As such, a fleeting opportunity exists to provide timely crisis interventions. This situation

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[53] Fathali M. Moghaddam and James N. Breckenridge, "The Post-Tragedy 'Opportunity-Bubble' and the Prospect of Citizen Engagement," 10 Years After: The 9/11 Essays, *Homeland Security Affairs* 7 (September 2011): 1–5.

underscores the importance of public safety agencies to develop an effective crisis intervention policy for first responders and gives them the opportunity to shape a robust work force ready for subsequent events.

Most importantly, the desired outcome is for first responders to receive care by having someone who will listen and help them find relief when battling PTSD, as well as public safety agencies maintaining a resilient work force. Tragedies will continue and first responders will need to respond; therefore, it is critical for the homeland security mission to have a strong work force of first responders who are not only cared for, but also available to handle traumatic incidents. If first responders are taken care of, they will take care of everyone else.

As seen in the examples of Hurricane Katrina, a lack of planning concerning the stress associated with a traumatic event affects the ability of first responders to execute their responsibilities. Approximately 250 police officers deserted New Orleans during the storm and at least two committed suicide.[54]

E.   METHODOLOGY

The research method the author uses is a comparative policy analysis with a multi-goal policy analysis approach. The research is formative and prescriptive. The research focuses on critical incident stress management, an alternative approach to crisis intervention known as psychological first aid, and the utilization of chaplains to mitigate PTSD in first responders following a traumatic incident.

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[54] CBS News, "New Orleans Police Chief Quits," February 11, 2009, http://www.cbsnews.com/8301-201_162-886417.html.

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II.   CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

A.   INTRODUCTION

This chapter examines CISM that has been identified as the primary standard of care for many public safety agencies following a crisis. This chapter also identifies the structure of CISM, how it is administered, and through previous meta-analysis and studies, assess its strengths and weaknesses.

Many first responders are routinely exposed to traumatic events in the course of their duties. As such, first responders are at risk for long-term problems identified as PTSD. PTSD is defined as "a psychological reaction that occurs after experiencing a highly stressing event (as wartime combat, physical violence, or a natural disaster) outside the range of normal human experience and that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event."[55]

In an effort to combat PTSD, Dr. Jeffery T. Mitchell introduced CISM in the 1980s as a powerful, cost effective approach to crises intervention.[56] CISM utilizes a psychological debriefing mechanism that enables groups or individuals to receive support following a traumatic incident.

Some researchers are convinced of CISM's efficacy and claim CISM programs are validated through qualitative analysis, controlled investigations, and meta-analysis; however, other research utilizing the same methods claim that CISM does not effectively mitigate PTSD and may be harmful. Since doubt exists, numerous organizations are discontinuing CISM as a crisis intervention tool. If CISM is such a great tool for PSTD, then why does so much controversy surface?

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[55] Merriam-Webster, "Post-Traumatic Stress Disorder," (n.d.). http://www.merriam-webster.com/medical/post-traumatic%20stress%20disorder.

[56] Everly and Mitchell, "A Primer on Critical Incident Stress Management (CSIM)," 1.

The majority of the studies conducted on CISM conclude that more research is needed on its efficacy. "Despite over 20 years of research, the efficacy of group psychological debriefs remains unresolved."[57] "The effectiveness of Critical Incident Stress Debriefing as a tool remains, at best, inconclusive."[58]

B.   PSYCHOLOGICAL DEBRIEFINGS

Psychological debriefings became known in World War I and World War II.[59] Commanders debriefed soldiers following a major battle to boost morale by having combatants share stories about what had happened during engagements.[60] Dr. Jeffery T. Mitchell (Clinical Professor, Emergency Health Services, University of Maryland, President Emeritus, International Critical Incident Stress Foundation Member and a member of the United Nations Department of Safety and Security Stress Working Group) reasoned that a similar approach might diminish stress among first responders.[61]

1.   Description of CISM

CISM utilizes a psychological debriefing mechanism that enables groups or individuals to receive support following a traumatic incident. CISM is designed to facilitate normal recovery and mitigate PTSD. The debriefing is usually held 72 hours to 14 days following a traumatic incident, and on average, takes 90 minutes to three hours to complete. Professionals or non-professionals conduct

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[57] Michelle R. Tuckey, "Issues in the Debriefing Debate for the Emergency Services: Moving Research Outcomes Forward," *Work & Stress Research Group, Centre for Applied Psychology, University of South Australia*, 2007, 106.

[58] James Jeannette and Alan Scoboria, "Firefighter Preferences Regarding Post-Incident Intervention," *Work & Stress* 22, no. 4 (October–December 2008): 314–326.

[59] Brett T. Litz et al., "Early Intervention for Trauma: Current Status and Future Directions," *Clinical Psychology: Science and Practice* 9, no. 2 (May 2002): 117.

[60] Ibid.

[61] Richard J. McNally, Richard A. Bryant, and Anke Ehlers, "Does Early Psychological Intervention Promote Recovery From Posttraumatic Stress?," *American Psychological Society* 4, no. 2 (2003): 55.

CISM and the levels of training to conduct debriefings vary. Dr. George Everly, Jr., (Johns Hopkins Center for Public Health Preparedness, Co-Founder and Chairman Emeritus International Critical Incident Stress Foundation), and Dr. Mitchell predicted their approach would emerge as "the standard of care" for intervention in the wake of a crises.[62]

2. Predominant Method for Crisis Interventions

Currently, 30,000 to 50,000 individuals are trained each year to conduct CISM debriefings.[63] Debriefings now occur in businesses, schools, hospitals, and the military.[64] Dr. Mitchell claims that in addition to mitigating stress and preventing PTSD, CISM may reduce sick days taken by stressed employees.[65] If Mitchell's claims were valid, public safety agencies would benefit from incorporating CISM as a standard practice. Mitchell also claims that a business's failure to incorporate a psychological service following a critical incident may constitute negligence and increase the risks of legal liability.[66]

C. CISM'S ROLE IN CRISIS INTERVENTIONS

As a solution to the risks facing first responders, CISM was designed to mitigate PTSD in first responders following a traumatic incident. It is a comprehensive, integrative and multi-component crisis intervention system. A crisis may include the following.

- Responding to or being a victim of a natural disaster
- Being a victim or witness of an attack involving deadly force
- Serious injury to yourself or another
- Gruesome injury or death of a child or elderly person

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[62] McNally, Bryant, and Ehlers, "Does Early Psychological Intervention Promote Recovery From Posttraumatic Stress?," 57.

[63] Ibid.

[64] Ibid., 56.

[65] Ibid., 57.

[66] Ibid., 74.

- Divorce, separation, or child custody dispute

- Lawsuits or internal investigations

- Financial difficulties[67]

CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions that may be applied to individuals, small functional groups, large groups, families, organizations, and even communities. The seven core components of CISM are defined below.[68]

- Pre-crisis preparation—Includes stress management education, stress resistance, and crisis mitigation training for both individuals and organizations

- Disaster or large-scale incident, as well as, school and community support programs including demobilizations, informational briefings, "town meetings" and staff advisement

- Defusing—A 3-phase, structured small group discussion provided within hours of a crisis for purposes of assessment, triaging, and acute symptom mitigation

- Critical Incident Stress Debriefing (CISD) — 7-phase, structured group discussion, usually provided one to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up, and if possible, provide a sense of post-crisis psychological closure

- One-on-one crisis intervention/counseling or psychological support throughout the full range of the crisis spectrum

- Family crisis intervention, as well as organizational consultation

- Follow-up and referral mechanisms for assessment and treatment, if necessary[69]

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[67] U.S. Army Corps of Engineers, "Criticial Incident Stress Management (CISM): Frequently Asked Questions," *Natural Resources Management Gateway to the Future* (2012): 1–6.

[68] Everly and Mitchell, "A Primer on Critical Incident Stress Management (CSIM)," 1.

[69] Ibid., 2.

1. Critical Incident Stress Debriefing (CISD)

CISD is a component of CISM and was developed to help law enforcement officers and emergency service workers understand that they are normal people experiencing normal reactions to abnormal events or situations. The concept behind CISD is to encourage free expression of thoughts, fears, and concerns in a supportive group environment after a major stressful incident. As short-term initial intervention, CISD often aids in preventing long-term effects caused by traumatic incidents. Team members undergo 16 hours of training before they can conduct a counseling session, which is usually scheduled within 48 hours after emergency workers have been involved in a critical incident. Almost 100 CISD teams operate on national, statewide, regional, and local levels.[70]

2. Debriefing

The debriefing is a structured group discussion concerning the critical incident and utilizes four group tools in the debriefing process. The group tools are identified as demobilization, crisis management briefing, defusing, and debriefing.

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[70] Tod Schimelpdenig, "Critical Incident Stress Debriefing—Helpful or Harmful?," *National Outdoor Leadership School*, 2004, http://www.nols.edu/nolspro/pdf/wrmc_proceedings_05_cisd_help_or_harm_schimelpfenig.pdf, 1.

Type	Demobilization	Crisis Mgmt Briefing (CMB)	Defusing	Debriefing (CISD)
When	After Shift	Anytime post-crisis	Within 12 hours	24 hours–10 days*
Who	Large numbers of responders	Organizations, Communities, Schools	Small Groups	Small Groups
Format	Passive–Information and rest if the focus	Semi-Active–Info plus short Q & A, Resources	Active, Loosely guided. Three stages	Very Active–Structured team, guided discussion through seven stages
Leader	Peer, Chaplain, or mental health professional	Peer, Chaplain, and/or mental health professional	Peer, Chaplain, or mental health professional	Trained leader and one mental health professional
Length	½ hour	1–1½ hour	20–45 minutes	1½–3 hours
Follow-up**	CISD	Assess need for CISD	Assess need for CISD	Closure or referral

*Debriefings may not be appropriate until 2–4 weeks (sometimes longer) following a disaster.
**During the CISM process, team members should watch for individuals who might need follow-up or referral for additional support.[71]

Table 2.   Four Group Tools Used in CISM[72]

As reported in the literature, common ground rules of CISD include the following.

- Voluntary participation
- No note taking or recording devices
- Not used as an operational critique or investigation of events
- Not a blame session[73]

[71] Schimelpdenig, "Critical Incident Stress Debriefing—Helpful or Harmful?," 3.

[72] Placer County Law Enforcement Chaplaincy, "Chapter 4 Critical Incident Stress Debriefing," (n.d.), http://placerchaplains.com/Documents/Chapter%204_Critical%20Incident%20Stress%20Debriefing.pdf, 3.

[73] Ibid.

D. EFFECTIVENESS

Some researchers are convinced of CISM's efficacy. Dr. Mitchell identified CISM as a good practice that represents a powerful, yet cost-effective approach to crises response.[74] Dr. Everly and Dr. Mitchell claim CISM programs are empirically validated through qualitative analysis, controlled investigations, and meta-analysis.[75] Additionally, they claim no evidence exists to prove CISM is harmful.[76] Dr. Everly and Dr. Mitchell argued, "The experiences of 700 CISM teams in more than 40,000 debriefings cannot be ignored. This is especially so when the overwhelming majority of the reports of debriefing services are extremely positive."[77]

1. Meta Analysis and Studies

Many examples of CISM/CISD successes exist. The following examples are provided.

Psychologist N. Bohl assessed the use of CISD with police officers. Those who received a CISD within 24 hours of a critical incident were compared to officers without CISD. Those with CISD were found to be less depressed, less angry and had less stress symptoms at three months than their non-debriefed colleagues.[78] Bohl studied the effectiveness of CISD with 30 firefighters who received CISD compared with five who did not. At three months, anxiety symptoms were lower in the CISD group than in the non-CISD group.[79]

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[74] Everly and Mitchell, "A Primer on Critical Incident Stress Management (CSIM)," 1.

[75] Ibid.

[76] Ibid., 2.

[77] McNally, Bryant, and Ehlers, "Does Early Psychological Intervention Promote Recovery From Posttraumatic Stress?," 58.

[78] Jeffery T. Mitchell, "Critical Incident Stress Debriefing (CISD)," *Trauma*, (n.d.), http://www.info-trauma.org/flash/media-e/mitchellCriticalIncidentStressDebriefing.pdf, 6.

[79] Mitchell, "Critical Incident Stress Debriefing (CISD)," 6.

Furthermore, a sample of 288 emergency, welfare, and hospital workers involved in traumatic incidents were examined. The results depicted that 96% of emergency personnel and 77% of welfare and hospital employees, who worked on traumatic events, stated that they had experienced symptom reduction that was attributed partly to attendance at a CISD.[80] The findings may be attributed to the placebo effect simply because of the worker's belief they will benefit from attending a debriefing.

Again, another study was conducted following a mass shooting in which 23 people were killed and 32 were wounded. Emergency medical personnel were offered CISD within 24 hours. Thirty-six respondents were involved in an assessment of the effectiveness of CISD interventions. Recovery from the trauma appeared to be most strongly associated with participation in the CISD process. In repeated measures, anxiety, depression, and traumatic stress symptoms were significantly lower for those who participated in CISD than for those who did not.[81]

Pre- and post-test comparisons of 41 crisis workers were conducted following a hurricane. The CISD intervention reduced posttraumatic stress symptoms in both groups.[82]

Likewise, additional studies show CISD's performance being positive. In a study, emergency personnel working the 1992 civil disturbance in Los Angeles were either given CISD or not, depending on the choice of the command staff. They had worked at the same events. Those who received CISD scored significantly lower on the Frederick Reaction Index three months after intervention, compared to those who did not receive CISD.[83]

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[80] Mitchell, "Critical Incident Stress Debriefing (CISD)," 6.

[81] Ibid., 7.

[82] Ibid.

[83] Ibid.

Additionally, in 1994, over 900 people drowned in the sinking of the ferry, *Estonia.* Nurmi contrasted three groups of emergency personnel who received CISD with one group of emergency nurses who did not receive CISD. Symptoms of posttraumatic stress disorder were lower in each of the CISD groups than the non-CISD category.[84]

Finally, an evaluation of group crisis interventions was undertaken in New York City following the World Trade Center Attacks on September 11, 2001. Workers offered crisis intervention services by their employers were compared to other workers whose employers did not offer any form of organized crisis intervention services. Assessments, conducted at one year, and again at two years after the traumatic events of September 11, indicate that those who received group CISM services demonstrated benefits across a spectrum of outcomes in comparison to workers without crisis intervention services.[85]

2.   CISM Benefits

In addition to CISM being successful with first responders, the cost is reported to be affordable compared to the benefits received by employees. One example is found in a study on traumatized bank employees by[86]. A year with no CISD assistance for employees was compared with a year in which a CISD program was used. Employees fared better with the CISM program. Sick leave, in the year in which the CISM program was utilized, was reduced by 60 percent. Additionally, workers compensation was reduced by 68 percent.[87] Workers compensation is defined as

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84 Mitchell, "Critical Incident Stress Debriefing (CISD)," *Trauma*, 7.

85 Ibid., 8.

86 Ibid., 7.

87 Ibid.

insurance paid by companies to provide benefits to employees who become ill or injured on the job. Through this program, workers are provided with benefits and medical care, and employers have the assurance that they will not be sued by the employee. The cost of workers' compensation benefits is based on the gross payroll and the number and severity of illnesses and injuries that type of employer experiences.[88]

Yet in another strong example, Western Management Consultants conducted a cost benefit analysis on a CISM program for nurses. The study involved 236 nurses. Sick time utilization, turnover rate and disability claims dropped dramatically after the program was implemented. The cost benefit analysis showed $7.09 was saved for every dollar spent on structuring the CISM program.[89]

CISM teams or team members are composed of police officers, dispatchers, fire fighters, nurses, doctors, EMT's, mental health professionals and clergy who volunteer their time to make services available. Network members are prohibited from accepting payment of any kind for services rendered.

While these examples indicate that CISM saved organizations money, many other examples exist in the literature.

In contrast, organizations adopting CISM must incur costs to become a member of the CISM organization. Required training, conferences, annual fees and yearly dues are required that provides a financial incentive for CISM to be advertised by its founder as a cost effective crisis intervention technique. Additionally, reported successes may be attributed to the expectations by employees that they will receive a benefit from a debriefing session, which is commonly referred to as the placebo effect.

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[88] Jean Murray, "U.S. Business Law/Taxes," *About.Com*, (n.d.), http://biztaxlaw.about.com/od/glossaryw/g/workerscomp.htm.

[89] Mitchell, "Critical Incident Stress Debriefing (CISD)," 7.

Furthermore, the majority of trauma survivors recover from a traumatic event without any intervention. The rate of recovery is higher for individuals who receive no intervention.[90]

3. Training

Organizations adopting CISM as a crisis intervention tool should be trained and certified by CISM. Mental health professionals must attend a two-day training session and participate in cross training in the public safety and EMS areas. Peer debriefers must also attend a two-day training session and participate in cross training, if deemed necessary. All team members must participate in ongoing continuing education to sharpen their skills and keep abreast of changes in the fields of stress management.

Also, peer debriefers conduct crisis intervention techniques with someone who does the same job. Peer supporters are typically not counselors or therapists but individuals trained to provide support to their coworkers. Peer supporters may be firefighters, police officers, dispatchers, support or administrative personnel, nurses, soldiers, or any worker in the same line of work. CISM claims peer support is very effective with police officers, who are often reluctant to cross the "thin blue line" to talk about their experiences with non-officers. Police peer support teams train other police officers in listening skills, problem solving strategies, stress management techniques, and referral options, and thus, allow cops to take care of cops.

Another tool to facilitate the delivery of CISM is to train and utilize chaplains. The International Critical Incident Stress Foundation, Inc. (ICISF) will grant certificates in specialized training and spiritual care to chaplains or pastors who complete the following courses.

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[90] McNally, Bryant, and Ehlers, "Does Early Psychological Intervention Promote Recovery From Posttraumatic Stress?," 49.

- Group Crisis Intervention

- Individual Crisis Intervention and Peer Support

- Suicide Prevention, Intervention and Post Intervention

- Advanced Group Crisis Intervention

- Pastoral Crisis Intervention I—Pastoral crisis intervention adds to the community and organizational psychological support resources. The purpose of this two-day course is to assist the participants in learning how pastoral interventions and traditional psychological crisis interventions may be effectively integrated. The course consist of the following.

  - Nature of human crisis

  - Nature of crisis intervention

  - Critical Incident Stress Management (CISM)

  - Signs and symptoms of the crisis state

  - The "crisis of faith"

  - Criteria for psychological triage

  - Strategic SAFER-Pastor Crisis Intervention Model (PCI)

  - Common PCI mistakes

  - Challenging PCIs91

- Pastoral Crisis Intervention II—This course builds on the foundations of Pastoral Crisis Intervention class. More specific advanced concepts and a specific field application in which pastoral crisis intervention is applied is covered. The course consists of the following.

  - Crisis intervention, CISM and PCI

  - Risks and potential adverse reactions

  - Advance topics in assessment

  - Principals of basic spiritual first aid

  - PCI with those expressing theodolitic concerns

  - The Incident Management System (IMS)

  - PCI with those expressing suicidal ideation

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91 International Critical Incident Stress Foundation (ICISF), "Crisis Intervention Stress Management (CISM) Training," Training for Chaplains, International Critical Incident Stress Foundation, n.d.

- PCI with those in acute bereavement
- Principles of death notification
- Principles and practices associated with self-care[92]

E.   INEFFECTIVENESS

Even though CISM is the most common form of early intervention for traumatized first responders, research not supporting its continued use is emerging.

1.   Meta-Analysis and Studies

Many studies create doubts about whether to continue to use CISM in the future. A meta-analysis evaluated seven studies that specifically examined single-session debriefings performed within one month after a traumatic event.[93] Five of the studies evaluated CISM, and three evaluated non-CISM interventions. Six of the reviewed studies utilized non-intervention controls.[94] Individuals who received no intervention and those who received non-CISM interventions actually fared better than those who received CISM interventions. Additionally, researchers found that CISD did not improve natural recovery with respect to other trauma-related disorders.[95]

A second meta-analysis evaluated 11 studies in which single-session psychological debriefings were provided within one month after a traumatic event.[96] These studies found CISM neither reduced psychological distress nor prevented the onset of PTSD.[97]

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[92] International Critical Incident Stress Foundation (ICISF), "Crisis Intervention Stress Management (CISM) Training."

[93] Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," 1.

[94] Ibid., 2.

[95] Ibid.

[96] Ibid.

[97] Ibid.

Additionally, CISM attempted two meta-analyses that supported CISM interventions. These studies were reported to be flawed and highly criticized by mainstream psychologists.[98] The Department of Psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, MD, criticized these two meta-analyses, stating, "Reports cited in a meta-analysis by Everly, Boyle and Lating; and Everly and Boyle, are not representative outcome studies."[99]

Other studies have questioned the validity of CISM. Several negative outcome studies are subsequently discussed.

FEMA conducted a three-year study on the effectiveness of CISD as an early intervention for traumatic stress in firefighters. Thorough assessments were made of 660 firefighters exposed to critical events, including some involved in the Oklahoma City bombing response. Of these, 264 had attended one or more CISM sessions. Participants actually felt worse after the sessions, but overall had better images of the world and their places in it. No relationship was found between debriefing and PTSD.[100]

In the Netherlands, researchers studied 243 traumatized police officers assigned to a debriefing group or to one of two control groups. Pre-tests and post-tests were administered. No differences in psychological morbidity were found between the groups at pre-test, at 24 hours post-trauma, or at six months post-trauma. However, at one week, they found that debriefed subjects exhibited significantly more PTSD symptoms than non-debriefed subjects. These findings were consistent with an earlier study of debriefing for police officers, conducted by these same researchers, in which a comparison of 46 debriefed and 59 non-

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[98] Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," 2.

[99] Ibid.

[100] Ibid.

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debriefed officers, found no differences at eight months post-exposure, but significantly more disaster-related symptoms at 18 months post-event in the group that received debriefing.[101]

Additionally, following the crash of an air ambulance in British Columbia, in which five people died, Canadian researchers evaluated the effectiveness of CISM provided for paramedics, physicians and nurses. They found that CISM did not appear to affect the severity of stress symptoms. They also found that those who had pre-existing stress-management routines appeared to have less severe symptoms at six months post-incident.[102]

Several studies have demonstrated an actual worsening of stress symptoms in people who have received debriefings. In one study, the levels of anxiety and somatization at four months post-accident had declined more in the non-debriefed group, while levels of hostility and psychiatric symptoms had actually risen in the debriefed group. In the same study group, three years post-accident, patients in the debriefed group had marginally more severe psychiatric symptoms, more severe pain, had recovered less, reported more impaired functioning and had greater financial problems because of the accident. At 13 months following their injuries, burn patients who had received debriefings actually had worse anxiety, depression, and PTSD symptoms compared to the non-debriefed control group.[103]

Likewise, a Norwegian study evaluated 115 firefighters involved in a major hotel fire that 47% described as the worst experience they had. Of these firefighters, 39 underwent formal debriefing. The results showed no significant difference between the debriefed group and the group that simply talked to their

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[101] Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," 2.

[102] Ibid.

[103] Ibid.

colleagues. In addition, they found that in spite of an extreme stress situation, the frequency of disturbing stress reactions following the event was low.[104]

2. Time of Intervention

Research on CISM suggests that early intervention is critical in helping individuals cope with a traumatic incident, but a gap has been discovered concerning the time of intervention. The author agrees that early intervention is critical in helping individuals coping with a traumatic incident, but he finds the description of early intervention problematic. CISD is generally conducted one to 10 days following a traumatic incident or it can be as long as weeks or months.[105] No consistency appears on when debriefings should occur. The main focus in treating first responders following a traumatic incident is providing a near to immediate response and taking care of their basic needs.

> The need for crisis intervention services is clear. Yet the efforts to provide those services must be well-timed and well measured. Crisis intervention services must complement and augment natural recovery and restorative mechanisms. They must not interfere with said mechanisms. This is true for wherever the crisis response is in evidence, whether for individuals, organizations, or entire communities. Consideration of the aforementioned principles may assist the crisis worker in the most effective application of crisis intervention strategies and tactics.[106]

3. Organizations Discontinuing CISM

Since research is beginning to conclude that CISM and similar interventions are harmful, at the least ineffective, numerous organizations are dropping or forbidding the practice. The National Institute of Mental Health (NIMH), in conjunction with the U.S. Department of Health and Human Services,

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[104] Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," 2.

[105] George S. Everly, Jr., "5 Principles of Crisis Intervention: Reducing the Risk of Premarure Crisis Intervention," *Editorial* (2000): 3.

[106] Ibid., 4.

Department of Defense, Department of Veterans Affairs, Department of Justice and American Red Cross, held a workshop to reach a consensus on the best practices in evidence-based early psychological intervention for victims/survivors of mass violence. In the report, following an exhaustive review of cross-culture literature on the subject, that panel specifically did not recommend CISM or psychological debriefing as an early-intervention practice.[107]

In a recent document on mental health regarding emergencies, the WHO stated, "Because of the possible negative effects, it is not advised to organize forms of single-session psychological debriefing that pushes persons to share their personal experiences beyond what they would normally share."[108]

Another trusted source, the British Health Service concluded, "Review of the best-designed studies suggests that routine debriefing (a single-session intervention soon after the traumatic event) is not helpful in preventing post-traumatic disorders."[109]

Even worldwide organizations like NATO are beginning to pull back their support of CISM. In the North Atlantic Treaty Organization (NATO), a Russia Advanced Research Workshop on Social and Psychological Consequences of Chemical, Biological and Radiological Terrorism, convened to discuss the social and psychological implications of terrorism, similarly concluded, "There is still no consensus on the role, if any, of very acute interventions. CISD can no longer be recommended."[110]

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[107] Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," 3.

[108] Ibid.

[109] Ibid.

[110] Ibid.

Similarly, in the 2000 Olympic Games in Sydney, the New South Wales (Australia) Health Department did not recommend CISD. They concluded that, "There is no evidence that CISD prevents PTSD or other psychological morbidity, and it may make some people worse."[111]

Additionally, the Australian Critical Incident Stress Association (ACISA), in its Guidelines for Good Practice for Emergency Responder Groups, stated, "Experience and systematic investigations have revealed a marked discrepancy between outcomes once presumed to be achievable (Mitchell, 1983; Mitchell and Everly,1995) and those that can be reliably delivered (Rose and Bisson, 1998)."[112]

Likewise, British Navy researchers performed a narrative review of various studies related to psychological debriefing and CISD with particular emphasis on how it impacted the British Royal Navy and Royal Marines. They concluded that, "Psychological debriefing cannot be considered safe, and thus it should not be routinely used."[113]

F.   CONCLUSION

Public safety agencies are critical to the homeland security mission. Policies to mitigate PTSD would benefit the first responder, agency, and the overall mission of homeland security. First responders will be routinely exposed to traumatic events in the course of their duties. As such, first responders are at risk for long-term problems identified as PTSD. PTSD may disrupt public safety agencies responsible for homeland security due to lost time from work, health care costs, and a less resilient work force capable and ready to respond to the next incident.

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[111] Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," 3.

[112] Ibid.

[113] Ibid.

CISM utilized by public safety agencies as a stand-alone practice is problematic. Some research identifies CISM as a successful cost effective practice to mitigate PTSD. Other research portrays CISM as ineffective and harmful to first responders and public safety agencies when confronting PTSD. Due to this inconclusiveness, many agencies have discontinued CISM as a tool when confronting PTSD. Furthermore, CISM suggests that early intervention is critical in helping individuals cope with a traumatic incident, but a gap has been discovered concerning the time of intervention. CISD is generally conducted one to 10 days following a traumatic incident or it can be as long as weeks or months.[114] Many of the studies conducted on CISM conclude that further research is needed to prove CISM's efficacy. "Despite over 20 years of research, the efficacy of group psychological debriefs remains unresolved."[115] "The effectiveness of Critical Incident Stress Debriefing as a tool remains, at best, inconclusive."[116] If CISM is such a great tool for PSTD, then does so much controversy exist?

While every effort should be made to provide the necessary care for first responders, decision makers of public safety agencies also need to know what crisis intervention tool is best. If CISM is not the best tool for crisis interventions, then an alternative approach by public safety agencies needs to be examined and researched.

A good starting point in researching the best practice for crisis intervention is identifying the victim's expectations. The placebo effect may be applicable in finding the best method due to psychological variables, such as motivation, expectancy, and conditioning, and may be significant variables driving both

[114] Everly, "5 Principles of Crisis Intervention: Reducing the Risk of Premarure Crisis Intervention," 3.

[115] Tuckey, "Issues in the Debriefing Debate for the Emergency Services: Moving Research Outcomes Forward," 106.

[116] Jeannette and Scoboria, "Firefighter Preferences Regarding Post-Incident Intervention," 314–326.

negative and positive outcomes.[117] For example, victims of trauma may have been conditioned on treatment methods provided by CISM in previous traumatic event exposures. If CISM was not effective or harmful to the victim, consciously or unconsciously, a nocebo effect will occur triggering a negative reaction. In this scenario, CISM would not be the best approach.

In contrast, if a victim sees the benefit of CISM and expects to be helped by a CISM intervention, the ability to continue and cope with a crisis is increased. Placebo effects are strongest when the provider and victim believe in the efficacy of the treatment.[118]

Due to the expectations and beliefs of a victim, research should incorporate the placebo effect in determining the best practice in crisis interventions.

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[117] Christopher J. Beedie and Abigail J. Foad, "The Placebo Effect in Sports Performance," *Sports Medicine* (2009): 313–329.

[118] Miller, "Williams James, Faith, and The Placebo Effect," 273–281.

III. PSYCHOLOGICAL FIRST AID (PFA)

A. INTRODUCTION

Terrorism, major disasters, serious accidents, and interpersonal or domestic violence often remind people of how fragile life can be. The attacks on 9/11, the shooting massacre at Virginia Tech, and Hurricane Katrina are examples of tragedies that changed lives forever. Lives are changed when people are injured, killed, or their property is destroyed. First responders are on the front lines when confronting these tragedies and see death and suffering up close. As a result, leaders of first responder organizations need methods to recognize the different levels of stress their employees are experiencing and identify ways they can "support their officers and minimize long-term effects of stress, including absenteeism, early resignation/retirement, depression, post-traumatic stress, substance abuse, and suicide."[119] One method emerging as the preferred response to crisis intervention is PFA. This chapter examines the structure of PFA and assesses its strengths and weaknesses. Additionally, this chapter also identifies for whom PFA is designed, who should deliver PFA, when PFA is utilized, when PFA should be administered, and PFA training.

PFA is now recommended in the federal guidelines found in the 2008 National Response Framework.[120] The "Medical Reserve Corp Psychological First Aid Field Operations Manual" identifies PFA as a process to reduce the initial distress caused by traumatic events. Additionally, PFA is consistent with research on risk and resilience following trauma and it is applicable and practical in field settings.[121] The Medical Reserve Corps, National Center for Child

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[119] Mark Chapin et al., "Training Police Leadership to Recognize and Address Operational Stress," *Police Quarterly* 11, no. 3 (2008): 338–352.

[120] Julie A. Uhernik and Marlene A. Husson, "Psychological First Aid: An Evidence Informed Approach for Acute Disaster Behavioral Health Response," *American Counseling Association Annual Conference,* Charlotte, 2009, 271–280.

[121] Ibid., 272.

Traumatic Stress, WHO, National Center for Post-Traumatic Stress Disorder (PTSD), and the National MRC Mental Health Work Group have developed a Psychological First Aid Field Operations Guide as a model of mental health intervention in the early response to disasters and other traumatic events. The PFA guide serves to fill a major gap in the field of major disasters and traumatic events by helping to standardize and clarify the concepts of PFA, an evidence-informed intervention strategy in disaster mental health response.[122]

B.   DESCRIPTION OF PSYCHOLOGICAL FIRST AID (PFA)

As early as the Civil War, the U.S. Army recognized that exposure to combat has stressful effects beyond physical injuries and disease.[123] Many terms were used in wars by the U.S. Army to identify stress soldiers were experiencing. The following terms were identified: (Civil War) "shell shock," (World War I) "battle fatigue," (World War II), "Combat Stress," and (Vietnam and after) "combat/operational stress."[124] As a result, PFA was devised at the end of World War II to combat stress experienced by soldiers.[125]

First responders routinely respond to traumatic events, such as terrorist attacks, major disasters, fatal accidents, and domestic violence. Two examples close to home for the author were the Virginia Tech Massacre on April 16 2007, where he saw 32 students who had been killed, and the terrorist attacks on September 11, 2001. The first responders at these events witnessed mass-causalities, destruction of property, and hurting families. The psychological and physical impact of the 9/11 attacks on the World Trade Centers is found in a report by New York Health Department in which more than 830 first responders

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[122] Uhernik and Husson, "Psychological First Aid: An Evidence Informed Approach for Acute Disaster Behavioral Health Response," 272.

[123] Chapin et al., "Training Police Leadership to Recognize and Address Operational Stress," 340.

[124] Ibid.

[125] Leslie Snider, Sonia Chehil, and Douglas Walker, "Psychological First Aid," *Mental Health and Psychosocial Support in Disaster Situations in the Caribbean* (n.d.): 98.

were identified to have died from 9/11 related illnesses—at least 300 of those were from cancers—others from respiratory complications, smoke inhalation disease, GERD, and suicide.[126] The loss of life is often confronted up close and personal by the first responders, and therefore, they can exhibit some of the same stress symptoms experienced by soldiers in combat. Dr. C. Williams, in "Peacetime Combat: Treating and Preventing Delayed Stress Actions in Police Officers," identified the stress experienced by soldiers in combat similar to the stress experienced by first responders.[127]

To combat stress experienced by first responders at traumatic events like the Virginia Tech Massacre and the attacks on 9/11, PFA has been developed as a crisis intervention tool to help first responders cope with the stress and reduce the possibility of developing PTSD. PFA is an evidence-informed modular approach to help families and the first responder in the immediate aftermath of disaster and terrorism. PFA is designed to reduce the initial distress caused by traumatic events and to foster short-term and long-term adaptive functioning and coping.[128]

> Psychological First Aid is supported by disaster mental health experts as the "acute intervention of choice" when responding to the psychosocial needs of children, adults and families affected by disaster and terrorism. At the time of this writing, this model requires systematic empirical support; however, because many of the components have been guided by research, there is consensus among experts that these components provide effective ways to help survivors manage post-disaster distress and adversities, and to identify those who may require additional services.[129]

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[126] Clint Richardson, "9/11 First Responders Need Your Help," *Reality Blog*, December 11, 2009.

[127] Chapin et al., "Training Police Leadership to Recognize and Address Operational Stress," 340.

[128] "Safety, Function, Action: Psychological First Aid Training," *DEEP Center*, 2010, http://www.deep.med.miami.edu/Images/PFA%20Flyer%20no%20contact.pdf, 1.

[129] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 2006, 5.

PFA does not assume that all survivors will develop mental health problems; however, it is based on understanding that victims of traumatic incidents will experience a broad range of early reactions that may include physical, psychological, behavioral, and spiritual actions.[130] The PFA approach utilizes five empirically supported principles to help lay the foundation for a PFA approach.

- Promote sense of safety
- Promote calming
- Promote sense of self and collective efficacy
- Promote connectedness
- Promote hope[131]

1.   For Whom Psychological First Aid Is Designed

Like CISM, PFA is intended for first responders and disaster relief workers, as well as victims of tragedies to include children, adolescents, parents/caretakers, families, and adults exposed to traumatic incidents.[132] PFA is also designed to be flexible and adaptable with other cultures.[133] Each crisis is unique and must be "tailored to the particular context, culture, ethnic, religious, and social situation."[134] To facilitate the sensitivity of culture differences, PFA offers training in culture competence to maintain customs, traditions, rituals, family structures, and gender roles. PFA also encourages providers to seek community culture leaders who best understand local customs.

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[130] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 6.

[131] Snider, Chehil, and Walker, "Psychological First Aid," 99.

[132] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 6.

[133] Ibid., 23.

[134] Snider, Chehil, and Walker, "Psychological First Aid," 98.

2.   Delivery of PFA

As identified in PFA literature, delivery of PFA can be accomplished through friends, family, co-workers, and clergy trained in PFA. Friends, family, and co-workers are often interconnected with the victim. In the author's experiences as a first responder and chaplain, victims are more likely to discuss their feelings with someone they know rather than a stranger. Clergy is often viewed as a trusted source able to discuss a victim's concern with confidentiality and without judgment. Mental health and other disaster relief workers can also deliver PFA. PFA can be provided by anyone; however, trained PFA providers are routinely found in metal health organizations, disaster relief organizations, and first responder organizations. Trained providers of PFA can be embedded in response units to include first responder teams, incident command systems (ICS), health care systems, school crisis response teams, faith based organizations, Community Emergency Response Teams (CERT), medical reserve corps, and other disaster relief organizations.[135]

3.   When PFA is Used

PFA providers respond to traumatic incidents when they are happening, or at the very least, in the immediate aftermath of a disaster. Timely intervention enables providers to identify quickly the stress first responders are experiencing. In the author's own experiences, he has discovered that when PFA occurs within minutes or hours, it is more effective because the provider is at the scene living through it. The provider is able to identify the first responders or victims who need assistance. The provider is in a position to understand what the first responders are experiencing, and therefore, helps them connect with the first responder's mental state. As articulated in all crisis intervention methods, timely intervention can be instrumental in a first responder's ability to process and quickly recover from a traumatic event.

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[135] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 6.

C.   CORE ACTIONS OF PFA

As reported in the PFA Medical Reserve Corps Field Operations Guide, PFA incorporates eight core actions to support survivors following a traumatic event.[136]

1.   Contact and Engagement

This action refers to responding to contacts initiated by survivors or initiate contacts in a non-intrusive and supportive manner. The first contact is important and should be managed in a respectful and compassionate way.[137]

PFA providers should pay attention to cultural differences. Physical or personal contact may vary from person to person and among various social groups. The PFA provider should approach the victim cautiously because different cultures have different levels of comfort with their personal space. In non-verbal communication, body language is different from culture to culture. Many gestures used in the United States have a different meaning and can be offensive to individuals in other cultures. Some examples are provided.

a.   *Gestures*

In the United States, the use of a finger or hand to indicate "come here please" is a gesture used to beckon dogs in some cultures and can be very offensive. Pointing a finger can also be rude to some cultures. Asians typically use their entire hand to point to something.[138]

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[136] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 19.

[137] Ibid., 23.

[138] Joanne Ikeda and Charles Tidwell, "Cultural Differences in Non-verbal Communication," (n.d.), *Vermont Department of Health,* http://healthvermont.gov/family/toolkit/tools%5CF-6%20Cultural%20Differences%20in%20Nonverbal%20Communic.pdf.

b.   *Touch*

In the United States, patting a child's head is considered a friendly or affectionate gesture. For Asians, this gesture is seen as inappropriate by many because the head is seen as a sacred part of the body. In the Middle East, the left hand is used for bodily hygiene and should not be used to touch other objects. Additionally, Muslim cultures view the touch between opposite gendered individuals in a public setting inappropriate.[139]

c.   *Eye Contact*

Western cultures view eye contact as attentiveness and honesty; however, in Hispanic, Asian, Middle Eastern, and Native American cultures, eye contact is viewed as disrespectful, rude, and lack of eye contact does not mean that someone is not paying attention. Women may avoid eye contact with men because it can be viewed as a sign of sexual interest.[140]

d.   *Working with Babies*

In Western cultures, it is common for adults to admire babies and young children and comment on how precious they are. Hmong and Vietnamese cultures avoid this type of gesture because they are afraid a spirit will overhear comments and steal the baby or bring them harm.[141]

Understanding culture differences is a very important component in delivering PFA, CISM, or any other crisis intervention technique. A core function of PFA is to **Look** at the scene and environment to include how people are acting. **Listening** to what is verbally being communicated and what is being communicated non-verbally, and **Linking** individuals with resources to include

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[139] Ikeda and Tidwell, "Cultural Differences in Non-verbal Communication."

[140] Ibid.

[141] Ibid.

family, friends, or someone in the same culture. If possible, when confronting different cultures, PFA providers should seek guidance from community culture leaders.[142]

Additionally, it is important to speak softly and calmly while identifying any pressing problem that needs immediate attention. If possible, when making contact with children or adolescents, first try to make contact with the parent or caregiver.[143]

Maintaining confidentiality with victims is critical. Also be aware of the Health Insurance Portability and Accountability Act (HIPAA) and the provisions related to disaster and terrorism.[144] Speaking from experience, reporters from the media will seek out first responders and care providers. If possible, victims should be protected from the media and PFA providers should not discuss any information with the media that could potentially breach confidentiality. Victims of a disaster are more inclined to express their feelings when speaking to someone in whom they trust, and who will maintain confidentiality.[145]

2.   Safety and Comfort

PFA providers help meet immediate and ongoing safety needs, and provide emotional comfort, such as a reduction of distress and worry. Comfort can be supported in the following ways.

- Do things that are active (rather than passive waiting), practical (using available resources), and familiar (drawing on past experience).
- Get current, accurate and up-to-date information, while avoiding survivors' exposure to inaccurate or excessively upsetting information.

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[142] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 23.

[143] Ibid.

[144] Ibid., 24.

[145] Ibid.

- Get connected with available practical resources.

- Get information about how responders are making the situation safer.

- Get connected with others who have shared similar experiences.[146]

Additionally, PFA providers should achieve the following benchmarks.

- Ensure immediate physical safety—help victims become as safe as possible. Determine if victim has any health related concerns or is in current need of medication. If available, contact relatives and ensure authorities are aware of any daily needs.[147]

- Provide information on disaster response activities/services.

- What to do next, what is being done to assist them, provide information on what is currently known about the unfolding event, available services, common stress reactions, and information on self-care, family care, and coping.[148]

- Attend to physical comfort—find ways to make the environment more comfortable.[149] For example, have adequate lighting, provide eyeglasses or other devices, blankets, clothing, and needed medication.

- Promote social engagement—facilitate group interactions as appropriate. It is often reassuring to be near people who are handling the crisis in a positive manner. Children should be put with adults or peers who are calm and will look to adults for cues about safety and appropriate behavior. Calm Individuals can talk with others who are distressed.[150] For example, at the Virginia Tech Massacre, crime scene technicians had to handle and process the bloody crime scene. Some handled it better than others, and through group interaction, were able to help and support others having a hard time.

- Attend to children separated from their parents/caregivers—provide easy to understand information, and if possible, set up a child-friendly space.[151]

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[146] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 27.

[147] Ibid.

[148] Ibid., 28.

[149] Ibid., 30.

[150] Ibid.

[151] Ibid., 31.

- Protect from additional traumatic experiences and trauma reminders—protect victims from unnecessary exposure to additional traumatic events to include sights, sounds, and smells.[152]

- Help survivors who have a missing family member—assist in obtaining updated information on missing persons. Additionally, help survivors when a family member or close friend has died. In doing so, the PFA provider must be aware of culture differences, religious beliefs, and rituals related to mourning.[153]

- Attend to grief and spiritual issues—attend to issues related to traumatic grief, support survivors who receive death notification, and support survivors involved in body identification. As provided in the PFA guide, become familiar with clergy who are a part of the disaster response team. It is common for individuals to rely on religious and spiritual beliefs as a way to cope with the death of a loved one. Many chaplains are trained to minister to all individuals regardless of religious tradition.[154]

3.   Stabilization (If Needed)

Calm and orient emotionally overwhelmed survivors. Be concerned about victims whose reactions to a crisis are so severe, they interfere with the survivor's ability to function.[155]

4.   Information Gathering

Assess immediate needs and concerns of survivors. Gather additional information, and tailor PFA interventions. Gathering information begins after contact and continues throughout PFA.[156] To best help the victim, the following information needs to be gathered.

- Nature and severity of experiences during the disaster
- Death of loved ones

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[152] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 32.

[153] Ibid., 33.

[154] Ibid., 39.

[155] Ibid., 49.

[156] Ibid., 57.

- Concerns about immediate post-disaster circumstances and ongoing threat

- Separation from or concern about the safety of loved ones

- Physical illness, mental health conditions and need for medications

- Losses of home, school, neighborhood, business and pets

- Extreme feelings of guilt and shame

- Thoughts about causing harm to self or others

- Availability of social support

- Prior alcohol or drug use

- Prior exposure to trauma and death of loved ones[157]

5.   Practical Assistance

Offer practical help to survivors in addressing immediate needs and concerns. Often exposure to a disaster is accompanied by a loss of hope. Favorable outcomes are found in those who have the following characteristics.

- Optimism (because they can have hope for their future)

- Confidence that life is predictable

- Belief that things will work out as well as can reasonably be expected

- Belief that outside sources act benevolently on one's behalf (responsive government)

- Strong faith-based beliefs

- Positive belief (for example, "I'm lucky, things usually work out for me")

- Resources, including housing, employment, financial[158]

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[157] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 61.

[158] Ibid., 65.

6.   Connection with Social Supports

Assist survivors to connect or re-connect with primary support systems. Social support is related to the emotional well-being and recovery following a disaster.[159]

7.   Coping Information

Offer verbal and written information on coping skills in the face of a disaster. Provide basic information about stress, review common psychological reactions to traumatic experiences and losses, and talk with children about body and emotional reactions.[160]

8.   Linkage with Collaborative Services

Inform survivors of services available to them at the time or in the future. PFA providers need to provide direct links to additional resources, as well as necessary referrals for children, adolescents, and adults. Additionally, promote connections in helping relationships.[161]

D.   PFA EFFECTIVENESS

Many mental health experts recommend the utilization of PFA in crisis interventions. Dr. Bledsoe and Dr. Litz, Department of Psychology, Harvard University, and Dr. Josef I. Ruzek, National Center for PTSD, as well as the WHO, recommend an alternative approach to CISM by utilizing psychological first aid.[162] Richard J. McNally, Department of Psychology, Harvard University, recommends psychological first aid if researched and proven to be useful. Dr. Jeffery T. Mitchell, University of Maryland, President of International Critical

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[159] National Child Traumatic Stress Network, "Psychological First Aid, Medical Reserve Corps Field Operations Guide," 69.

[160] Ibid., 77.

[161] Ibid., 93.

[162] Ruzek et al., "Psychological First Aid," 1–18.

Incident Stress Foundation, claims CISM is a form of first aid.[163] "While psychological first aid has not yet been systematically studied, experience in the field suggests that it will be acceptable to and well received by consumers."[164] The author has validated this quote through research and from his own experiences as a chaplain. He has served as a chaplain for 20 years in the Virginia State Police. He also utilized PFA when a trooper in his command was killed in the line of duty. The following is a synopsis of that event.

On June 24, 2011, the author received a call to respond to an accident scene involving one of his troopers. This young trooper was killed instantly when he responded to a call for assistance and his police vehicle slammed into a steel pole. En-route to the call, the author contacted other chaplains, as well as his CISM team. The scene was horrific and first responders were struggling to cope with the loss of their comrade. He began to pray with and give counsel to the first responders, shared their grief, and helped take some of the burden they were experiencing by listening, encouraging, speaking calmly, and praying. One first responder broke down and began to cry over his dead co-worker. After the author came along beside him, prayed and comforted him, he was able to finish his role in the investigation. As a result, the investigation was completed quickly. After this traumatic incident was over, CISM conducted debriefings with the first responders involved in this fatal crash. Some of the first responders did not attend the debriefing. First responders that did attend remained silent. As a chaplain, the author was able to establish relationships with the first responders and was instrumental in helping his responders process and deal with this fatal crash. Additionally, he was equipped to identify first responders with potential PTSD concerns and help find relief if professional counselors were needed. PFA in this incident provided a sense of physical and psychological safety by offering comfort, support, and reassurance.

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[163] Everly and Mitchell, "A Primer on Critical Incident Stress Management (CSIM)," 2.

[164] Ruzek et al., "Psychological First Aid," 4.

As in the United States, other countries are frequently engaged in terrorist attacks, natural disasters, and traumatic incidents. In examination of the methods utilized by other countries, PFA has been identified as a tool for crisis interventions in Australia, Japan, and Israel. The latter's experience is discussed next.

1.   Israel's Experience in Dealing with Critical Incidents

Israel has a wealth of experience in dealing with traumatic incidents, and as a result, is a good place to look when examining crisis intervention methods. First responders and Israeli citizens have been exposed to terrorist attacks, and as a result, are at risk from suffering acute stress. Victims suffering from acute stress are the bulk of the casualties and outweigh those with physical injuries.[165]

Israel's first line of defense to address acute stress is to intervene as soon as possible.[166] Intervention is accomplished by providing PFA.

Israel is a densely populated country on the eastern shore of the Mediterranean Sea. Israel covers 22,072 square km (8,522 square miles). The population of Israel is approximately 7.3 million. Life expectancy for Israeli citizens is 80 years for men and 84 years for women. The main exports from Israel are computer software, military equipment, chemicals, and agricultural products. The gross national income per capita is $27,170. The major religions in Israel are Judaism, Islam, and Christianity.[167]

Israel has many volunteer organizations. Zaka is one of these organizations and is comprised of approximately 1,500 volunteers who are largely orthodox Jewish men. Zaka is an additional response organization

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[165] Ilan Kutz, and Avi Bleich, "Psychological First Aid, Acute and Long-Term Treatment Following Terrorist Attacks—Mental Health Interventions in a General Hospital Following Terrorist Attacks: The Israeli Experience," in *The Trauma of Terrorism*, ed. Yael Danieli, Danny Brom and Joe Sills (Binghamton: The Haworth Maltreatment & Trauma Press, 2005), 425–437.

[166] Ibid., 429.

[167] "Middle East: Israel Profile," *BBC News*, December 14, 2011, http://www.bbc.co.uk/news/world-middle-east-14628840.

responding to the scenes of disasters and terrorist attacks. It provides PFA to victims, and prepares the bodies of those killed.[168] Zaka also offers courses and workshops that provide first responders with skills to release depressing emotions, as well as how to engage their inner strength. Zaka is trained to identify first signs of stress and those who are in need of therapy.[169]

The Israel Ministry of Health has adopted the following principles for interventions by PFA non-professionals.

- Establish personal contact with the survivors and provide words of comfort or supportive touch

- Encourage survivors to verbalize their experiences

- Provide orienting information about what happened and what is about to happen

- Ensure physical needs, such as hydration, food, and rest when appropriate

- Enable contact with any significant other as possible through phone or personal contact[170]

If further treatment of first responders is needed following a traumatic incident, professional group interventions are employed. The optimal group is 5–12 individuals and is led by two experienced mental health workers. The average group intervention time is 45 minutes and they can process 30–45 people within three hours. Three or four groups can be held simultaneously when a massive number of casualties is present.[171]

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[168] Nadav Morag, *Comparative Homeland Security: Global Lessions* (Hoboken: John Wiley & Sons, Inc.), 2011.

[169] "The Emotional Strength of Zaka Volunteers," *American Friends of Zaka*, 2012, http://www.zaka.us/show.asp?PID=14#.T0q-SVsw284.

[170] Kutz and Bleich, "Psychological First Aid, Acute and Long-Term Treatment Following Terrorist Attacks—Mental Health Interventions in a General Hospital Following Terrorist Attacks: The Israeli Experience," 425–437.

[171] Ibid., 432.

Group interventions attempt to achieve the following objectives.

- Shared fate—reduces the sense of isolation

- Mutual support and human contact—enhances coping and fosters autonomy and safety

- Construction of narrative—helps differentiate the past from present. Puts experience into words.

- Repeated exposure—retelling event without re-experiencing it

- Heart storming, process of sharing—group support helps each member express emotions[172]

The group encounter is not identical to the CISM model utilized in the United States that relies more on recognized group dynamics. The immediate objective is to restore orientation in time and space, turn chaos into order, and provide a safe place and sense of control.[173] At the end of group intervention, those identified to be at risk for acute stress disorders or PTSD are provided with instructions and options for further care.

2. Efficacy of PFA When Incorporating Spirituality

"When a disaster strikes, individuals will frequently turn to clergy/chaplains for leadership, advice, comfort, compassion and faith." [174] Clergy trained as PFA providers are in the perfect position to accommodate the spiritual needs of survivors. Research provides some statistics into the successes of counseling individuals suffering from posttraumatic stress utilizing religious coping behaviors. Dr. H. G. Koenig, Dr. K. I. Pargament, and Dr. J. Nielsen, Department of Psychiatry, Duke University Medical Center, Durham, North Carolina, conducted a study between religious coping behaviors and non-religious coping behaviors. These authors concluded that religious coping behaviors relate better

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[172] Kutz and Bleich, "Psychological First Aid, Acute and Long-Term Treatment Following Terrorist Attacks—Mental Health Interventions in a General Hospital Following Terrorist Attacks: The Israeli Experience," 433.

[173] Ibid., 432.

[174] Stephen B. Roberts and Willard W. C. Ashley Sr., "Preface," in *Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy* (Woodstock: SkyLight Paths Publishing, 2008), xi–xiii.

to mental health than non-religious coping behaviors.[175] Additionally, Doctor L. R. Propst from the Department of Counseling Psychology, Graduate School of Professional Studies, Lewis and Clark College, Portland, Oregon, conducted controlled trials and concluded religious therapy results in significantly faster recovery from depression when compared with standard behavioral therapy.[176]

Furthermore, the significance of incorporating spirituality in the wake of a disaster was discovered in a national poll conducted by the American Red Cross one month following the 9/11 terrorist attacks. Results of the poll showed approximately 60% of all survivors said they would likely seek help from a spiritual counselor, compared to 45% of all respondents who would seek help from a physician, and 40% who would seek help from a mental health care professional.[177] Additionally, statistics claim 97% of Americans believe in God and 90% pray; as a result, it is not surprising that people turn to their faith or spiritual roots when experiencing crisis or stress.[178]

3.   Training

The National Child Traumatic Stress Network (NCTSN) provides a 6-hour interactive course that puts the participant in the role of a provider in a post-disaster scene. This professionally narrated course is for individuals new to disaster responses who want to learn the core goals of PFA, as well as for seasoned practitioners who want a review.[179] It features innovative activities, video demonstrations, and mentor tips from the nation's trauma experts and survivors. PFA online also offers a learning community in which participants can

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[175] H. G. Koenig, K. I. Pargament, and J. Nielsen, "Religious Coping and Health Status in Medically Ill Hospitalized Adults," *Journal of Nervous and Mental Disease* (1998): 513–521.

[176] L. Rebecca Propst, "Comparative Efficacy of Religious and Nonreligious Cognitive-Behavioral Therapy for the Treatment of Clinical Depression in Religious Individuals," *Journal of Consulting and Clinical Psychology* (1992): 94–103.

[177] Farkas and Hutchison-Hall, "Religious Care in Coping with Terrorism," 565–576.

[178] Taylor, "Spiritual First Aid," 106–118.

[179] National Child Traumatic Stress Network, "Learning Center for Child and Adolescent Trauma, Psychological First Aid Training," 2012, http://learn.nctsn.org/course/category.php?id=11.

share about experiences using PFA in the field, receive guidance during times of disaster, and obtain additional resources and training.[180] The development of the training was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for Post Traumatic Disorders (NCPTSD), National Association of County and City Health Officials, (NACCHO), U.S. Department of Health and Human Services (HHS Office of the Surgeon General), and Office of the Civilian Volunteer Medical Reserve Corps. Additionally, NCTSN provides a PFA trainer site and is intended for those individuals who have completed a PFA trainer course and will be providing trainings to others on the use of PFA. The site includes documents, web forums, and a calendar of upcoming presentations and meetings.[181]

Additionally, the International Association for Continuing Education (IACET) has authorized the American Red Cross to provide PFA training. Also, the WHO has published a PFA Guide for Fieldworkers. These guidelines explain how to provide basic support to people in the immediate aftermath of extremely stressful events.[182]

E.   LIMITATIONS OF PFA

At present, a need exists for evaluation and research of PFA principles. The development of random controlled trials in a disaster environment poses ethical and research roadblocks; however, research efforts continue to provide further support on the overall efficacy of PFA.[183] The PFA guide was developed to reflect current best practices in crisis interventions based on research, expert

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[180] National Child Traumatic Stress Network, "Learning Center for Child and Adolescent Trauma, Psychological First Aid Training,"

[181] Ibid.

[182] "Red Cross Offers Continuing Education Credits," American Red Cross, (n.d.), http://www.redcross.org/portal/site/en/menuitem.1a019a978f421296e81ec89e43181aa0/?vgnext oid=2ff51516a138e110VgnVCM10000089f0870aRCRD.

[183] Uhernik and Husson, "Psychological First Aid: An Evidence Informed Approach for Acute Disaster Behavioral Health Response," 271–280.

consensus, and practical experience.[184] Abraham Maslow identified basic physical and psychological needs, and certainly, is a good place to start when examining how to best deliver and measure the success providing comfort through PFA principles. However, an evidence-based approach to crisis interventions is necessary to prove its efficacy.[185] The PFA guide does include evaluation measures that can be used to evaluate the types of issues and concerns experienced by survivors.

Additionally, the National Child Traumatic Stress Network, Terrorism and Disaster Working Committee has formed a sub-committee to assess how PFA is being used and to what effect.[186]

1. Future Studies of PFA

The author recommends public safety agencies conduct further research into the possibilities of incorporating PFA. The methodology recommended to research and develop a PFA policy may include the following.

- Specifying the PFA intervention model—Define core principles and techniques for PFA in a manual format. Develop field operation guide for PFA providers. Evaluation on the effectiveness of PFA is not possible without clear guidelines. Assess if PFA providers are able to utilize their skills in preparedness drills and training exercises and offer a set of skills that can be measured systematically. Conduct studies of the actions provided by PFA providers through records generated when providing PFA.[187]

- Specifying outcomes—Recall purpose of PFA that is to reduce initial distress caused by traumatic events and foster short-term and long-term adaptive functioning of survivors. Outcomes should be measured and could be assessed by utilizing self-reports of survivors soon after PFA is delivered. Survivors could be asked to describe or rate their experience after receiving PFA.[188]

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[184] Eric M. Vernburg et al., "Innovations in Disaster Mental Health: Psychological First Aid," *Professional Psychology: Research and Practice* (2008): 381–388.

[185] Ibid.

[186] Ibid.

[187] Ruzek et al., "Psychological First Aid," 12.

[188] Ibid.

- Clarify evaluation design issues—It would be difficult to conduct a randomized controlled trial on PFA but measuring types of mental health interventions offered in the first few days and weeks is more feasible. Match components of PFA with the survivor's most immediate needs and circumstances. Have a written record of survivor's immediate needs and PFA provider's actions and recommendations.[189]

F.   CONCLUSION

The author has been a Virginia State Trooper for 26 years. During 20 of these years, he also had the privilege of serving as a chaplain. His experiences as a first responder and as a chaplain have put him into a unique position to evaluate the efficacy of crisis intervention techniques. He has observed that PFA and chaplains are often well received by victims in a crisis. Could this observation be in part a result of the placebo effect? A placebo response reflects a mind and body reaction caused by psychological factors, such as expectations, beliefs, and meaning.[190] Placebo is derived from the Latin verb meaning "to please."[191] If victims in a crisis believe they will be pleased from PFA or chaplain intervention, the probability of stress being mitigated is very good.

The PFA and chaplain intervention at a crisis provides a mechanism that evaluates the environment and stress victims are experiencing. They look, listen, and link victims to resources that help a victim maneuver through the crisis. Victims expect this, and therefore, may exhibit a placebo response. Sometimes during a crisis, a PFA or chaplain provider never say a word. Just going through the crisis with the victim sends a message of caring and listening if needed. Placebo responses can have a powerful effect on victims of trauma; however, responses could be positive or negative.

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[189] Ruzek et al., "Psychological First Aid," 13.

[190] Richard Kradin, "The Placebo Response," *Perspectives in Biology and Medicine* (2004): 328–338.

[191] Ibid.

In contrast to a positive experience in a crisis, a victim may recall a past experience in which a crisis management team did not meet expectations or made coping with the trauma more difficult. When providing PFA or any other crisis intervention method, the placebo effect should be weighed against the positive or negative reaction being exhibited by the victim that could enhance the response of a provider in delivering care to a victim suffering from trauma.

Regardless of the crisis intervention technique employed, the author has found that chaplains, when integrated into crisis intervention methods, are instrumental in addressing the needs and concerns of individuals involved in traumatic incidents. Critical incident stress management has a component for the utilization of chaplains; however, in the author's opinion, the structure of PFA is more conducive to the roles of a chaplain. The next chapter examines and evaluates the role of chaplains when providing PFA.

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IV. CHAPLAINS ROLE IN PROVIDING PSYCHOLOGICAL FIRST AID

A. INTRODUCTION

> Protective Services professionals (e.g., law enforcement officers, firefighters, military personnel) are on the front line for exposure to acts of terrorism that show no sign of abating. Managing the psychological consequences associated with experiencing these events has implications beyond safeguard well-being. Stress adversely affects performance in circumstances that demand high levels of attention and creative solutions to emergent problems.[192]

In times of a crisis or trauma, to whom do people turn? RAND conducted a study less than a week after 9/11 and discovered that people relied primarily on two resources, one another and their understanding of God.[193] The study also reported that 90% turned to prayer, religion, or spiritual feelings, which is more than the 85% of Americans who report that religion is fairly or very important.[194] In the Oklahoma City bombing, survivors were found consistently to use "positive religious coping strategies" as a means to work through the trauma of the attack.[195]

As a result of research pointing to the majority of people relying on God in the face of a tragedy, chaplains can be a valuable resource to victims and first responders during and after a traumatic event. "When a disaster strikes, individuals will frequently turn to chaplains for leadership, advice, comfort,

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[192] Douglas Paton and John M. Violanti, "Terrorism Stress Risk Assessment and Management," in *Psychology of Terrorism*, ed. Bruce Bongar, Lisa M. Brown, Larry E. Beutler, James N. Breckenridge, and Philip G. Zimbardo (New York: Oxford University Press, Inc., 2007), 225–245.

[193] Timothy A. Kelly, "The Role of Religion, Spirituality, and Faith-Based Community in Coping With Acts of Terrorism," in *Psychollogy of Terrorism*, ed. Bruce Bongar, Lisa M. Brown, Larry E. Beutler, James N. Breckenridge, and Philip G. Zimbardo (New York: Oxford University Press, Inc., 2007), 137–152.

[194] Ibid., 137.

[195] Ibid.

compassion and faith."[196] Chaplains should always be available for the traumatized and are typically viewed as a trusted source; however, some victims may not want a chaplain to help them in a crisis. Although the author believes this number may be small, other avenues to deliver PFA for the traumatized should also be available. Friends, family, co-workers, trained citizens, and mental health professionals can deliver PFA. "But for many trauma victims, chaplains can offer more: a level of comfort, a means of grace, of touch of divine in the midst of the struggle to cope with incomprehensible tragedy."[197]

This chapter examines the historical evidence of chaplains being utilized in traumatic events, the role of chaplains, necessary education for chaplain certification, training necessary to be effective in disasters and spiritual care, and why some agencies may limit the use of chaplains.

B.   HISTORY OF CHAPLAINS PROVIDING SPIRITUAL CARE

Spiritual care has a long history in human societies. In the modern era, Anton Boisen recognized the need for spiritual care, and is highly regarded as a pioneering figure in hospital chaplaincy and clinical pastoral education.[198] Military chaplains have a history of serving beside soldiers and going into harm's way with them.[199] In 1996, Congress passed the Aviation Disaster Family Act to improve support for family members after an aviation crash. Through the Red Cross, and the Association of Professional Chaplains, a spiritual support team encompassing the Association of Clinical Pastoral Education (ACPE), National Association of Catholic Chaplains (NACC), International Association of Police Chaplains, and the Federation of Fire Chaplains, developed the Spiritual Aviation Incident Response Team (SAIR Team). This team has helped the Red Cross and

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[196] Roberts and Ashley, "Preface." xi-xiii.

[197] Kelly, "The Role of Religion, Spirituality, and Faith-Based Community in Coping With Acts of Terrorism," 137–152.

[198] Becker, Bodin, and Schmidt, "Impact and Heroic Phases: Disaster Chaplains and Chaplaincy," 86–105.

[199] Ibid., 100.

National Transportation Safety Board (NTSB) understand the important role of spiritual care in disaster response.[200] The SAIR Team's role is used at all aviation disasters for family members of victims and first responders: Their responses have expanded from transportation disasters to terrorist and natural disasters.[201] Over 900 of these members were deployed following the terrorist attack on 9/11,[202] and many were deployed following the aftermath of Hurricane Katrina.[203]

C.   CHAPLAIN'S ROLE

> Just as chaplains are expected to be involved in the complete cycles of people of faith, so are they to be involved throughout the entire crisis continuum---before, during, and in the aftermath. They should be present anytime and anywhere throughout crisis incidents. The chaplaincy has a singularly unique expertise to provide crisis spiritual assessment and mending.[204]

After 9/11, the Department of Justice distributed the Office for Victims of Crime Handbook for coping after terrorism. Many times, the handbook references that victims of terrorism may need "professional or spiritual counseling," meaning help from a counselor or a chaplain.[205] Chaplains providing aid can help mitigate the impact of the spiritual, psychological, and physical aspects of a crisis. When utilizing chaplains, chaplains should be trained in disaster care and should not

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[200] Becker, Bodin, and Schmidt, "Impact and Heroic Phases: Disaster Chaplains and Chaplaincy," 101.

[201] Ibid., 100.

[202] Davidowitz-Farkas and Hutchison-Hall, "Religious Care in Coping with Terrorism," 565–576.

[203] Becker, Bodin, and Schmidt, "Impact and Heroic Phases: Disaster Chaplains and Chaplaincy," 86–105.

[204] Karen H. Stocks, "Understanding The Chaplains Role in an Age of Weapons of Mass Destruction," *Military Medicine* 166, no. 12 (October 2001): 55.

[205] Kelly, "The Role of Religion, Spirituality, and Faith-Based Community in Coping With Acts of Terrorism," 137–152.

advocate for any one faith, belief system, proselytizing, or imposing any belief or rituals. In the most simplistic terms, a chaplain's role is to provide care and comfort for people in all times of need.[206]

Chaplains should respond to a traumatic incident within minutes or hours to implement the look, listen and link strategy. Through timely intervention, the ability to look, listen, and link victims of a tragedy for care is enhanced. Additionally, there is something to be said about going through a crisis with a first responder or victim of a tragedy. Often chaplains are viewed as someone who understands what is being experienced because they are there. First responders are often confronted up close with death and their own mortality. They begin to ask questions ranging from life and death, to sin and forgiveness. A chaplain is able to discuss these matters without judgment and with confidentiality. In much of the research discovered on crisis interventions, timely intervention can be instrumental in a first responder's ability to process and quickly recover from a traumatic event.

A chaplain utilizing PFA incorporates three basic PFA action principles.

- Look—Check for safety, such as ensuring the scene is safe and secure. If the provider becomes a victim, rescue efforts could be hindered and matters worsened. Check for people with obvious urgent basic needs, and check for people with serious distress reactions.

- Listen—Approach people who may need support. Ask about people's needs and concerns. Listen to people and help them feel calm.

- Link—Help people address basic needs and access services. Help people cope with problems. Provide information and connect people with loved ones and social support.[207]

The basic actions and goals of a chaplain when providing PFA care at a disaster are as follows.

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206 Taylor, "Spiritual First Aid," 106–118.

207 World Health Organization, War Trauma Foundation and World Vision International. *Psychological First Aid: Guide for Field Workers.* Geneva: WHO, 2011, 18.

- Stabilization and introduction—Provide a calming presence and show caring through words and actions. For example, a chaplain may offer a bottle of water. Introductions are the first step in stabilizing a situation. The assessment of psychological, emotional, and spiritual needs begins with making a connection.[208]

- Acknowledgement—Involves attentive and active listening to people in crisis. If they chose to speak about the experience, listen; however, do not make them to tell their story if they do not want to, which for some, could make the problem worse. The goal should be to mitigate the effects of the crisis and refer them if further care is needed.[209]

- Facilitating Understanding—This action helps by validating the experience and providing information on common stress reactions. For example, provide education materials, such as handouts on stress, what to expect, and how to get further help if needed.[210]

- Encouraging adaptive spiritual coping—Through active listening, a chaplain can identify strategies to help a first responder or victim through the crisis. If a coping strategy has worked in the past, encourage them to use it again. For many people, faith and religious tradition are strong coping mechanisms. If praying or facilitating spiritual rituals are appropriate, do them because it can be a powerful tool for short- and long-term healing and resilience. If a spiritual request is made, provide a safe space to facilitate the request whether of the victim's faith or not.[211]

- Referral—Provide a bridge to resources. Resources may include temporary housing through the Red Cross or Salvation Army, mental health provider or grief support group, funeral director, financial planner, Department of Motor Vehicles, licensed contractor, etc....[212]

A chaplain should come to any crisis with the right attitude. A prayerful heart is important and a chaplain needs to have the mindset of being there to serve. Egos and personal agendas have no place if a chaplain is to be effective. If someone at a crisis does not want to talk, respect this wish.[213]

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[208] Taylor, "Spiritual First Aid," 106–118.

[209] Ibid., 109.

[210] Ibid., 110.

[211] Ibid.

[212] Ibid.

[213] Ibid., 111.

When performing the role of a chaplain while assigned to a first responder organization, a chaplain's success has been attributed to the following guidelines.

1   Be sure first responders know confidentiality will be maintained unless they are a danger to themselves or others.

2.   Use a formal title, which fits with the structure of most first responder organizations and often opens doors to communication.

3.   Be sure first responders know they have the support of a chaplain. Get to know them and be a familiar presence at the station prior to a crisis. Be approachable.

4.   If possible, and qualified, volunteer to serve as a chaplain to demonstrate support for first responders because of caring.

5.   Take all the training necessary to be prepared for any situation.

6.   Do not try to mold people to a chaplain's image.

7.   Be self confident.

8.   Do not be a religious salesman. Strive instead to develop relationships.

9.   Know when to turn a person over to someone better qualified who can help. Remember a chaplain is a resource.

10. Be mindful that being a chaplain is a 24-hour job. The biggest obstacle may be the lack of time.[214]

D.   TRAINING FOR CHAPLAINS PROVIDING DISASTER SPIRITUAL CARE

Most chaplains should hold a bachelor's degree plus theological education at the graduate level, which involves a minimum of three years at an accredited school. Accreditation needs to be from an accredited institution that is a member of the Council on Higher Education Accreditation (CHEA), such as the Association of Theological Schools or one of the regional Association of Colleges and Schools or its equivalent. Generally, four (4) units of Clinical Pastoral Education (CPE provided by ACPE, NACC or CAPPE) are required. Documentation of one year of full-time chaplaincy experience after completion of

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[214] Jim Weiss and Mickey Davis, "Establishing a Chaplaincy Program," *Law & Order* 56, no. 4 (April 2008): 84.

four (4) units of CPE is also generally expected. In addition, the chaplain should have demonstrated competency in areas of chaplaincy care, as outlined by the national Common Standards for Professional Chaplaincy and ordination or commissioning to function in a ministry of pastoral care. Finally, the aspiring chaplain should have an ecclesiastical endorsement by a recognized faith group for ministry in a specialized setting.[215]

In regards to disaster spiritual care, the Red Cross, International Association of Police and Fire Chaplains, CISM, PFA, and many other institutions provide training modules for chaplains. Some of the topics covered are as follows.

- The experience of working in a chaotic environment
- Disaster response mapping: what are local disaster response agencies and their roles?
- The culture of natural disaster response teams and agencies
- Ritual, prayer, funeral, memorials, sacred space and faith community support
- Referral as an art, not a failure
- Knowledge of various agents and materials that may be used by terrorists and their implications
- Finding, using and sharing religious resources
- Compassion, fatigue, secondary traumatization and burnout: how to avoid them
- Flexibility[216]

Additionally, the following is also recommended.

- Disaster simulations
- Ambulance "ride-alongs"
- Acquaintance with recovery workers

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[215] "The Benefits of Board Certification," *Board of Chaplaincy Certification INC,* (n.d.), http://www.professionalchaplains.org/uploadedFiles/For_Administrators/BCC%20Benefits%20for%20Administrators.pdf.

[216] Kelly, "The Role of Religion, Spirituality, and Faith-Based Community in Coping With Acts of Terrorism," 137–152.

- Functioning in a designated crime scene

- Death notifications and body identification

- Functioning as part of an interdisciplinary team[217]

Another training model is found in the Department of Mental Health and Center for Public Health Preparedness (John Hopkins Bloomberg School of Public Health) and the Department of Psychiatry and Behavioral Sciences (John Hopkins School of Medicine). These institutions have collaborated to develop a training program for PFA and disaster ministry. The curriculum involves four modules.

- Module I: Stress Reactions of Mind-Body-Spirit

Topics are an overview of basic response patterns, routine signs and symptoms of stress, other common expected reactions to stress (e.g., anger, irritability), disruptive later stage reactions (e.g., physical and mental breakdowns, suicide, alcohol, and substance abuse), critical incident stress, PTSD characteristics, and recognition of how stress and fear may spread.

- Module II: Psychological First Aid and Crisis Intervention

Topics are definitions and overview of crisis interventions and psychological first aid, overview of individual psychological first aid, acute psychological first aid for suicide intervention, and large group psychological first aid.

- Module III: Pastoral Care and Disaster Ministry

Topics are definitions of pastoral care in the context of a disaster, key features of disaster ministry, pastoral care versus disaster pastoral care, and spiritual/religious dimensions in pastoral care responses, and cautions.

- Module IV: Practical Resources and Self Care

Topics are community resources in disasters, incident command systems, exercises to generate information on resources within and outside the spiritual

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[217] Kelly, "The Role of Religion, Spirituality, and Faith-Based Community in Coping With Acts of Terrorism," 572.

community, examples and discussion of outside agencies, compassion fatigue and burnout, and family disaster plans to include evacuation and supply kits.

E.   LIMITATIONS OF CHAPLAINS

Although research discussed in Chapter I clearly shows spiritual coping mechanisms are proven to be effective, and as discovered by the RAND study previously discussed in this chapter, in which the majority of victims seek religious coping mechanisms, the resources to provide this type of care are frequently overlooked. Trained and certified chaplains in disaster care, unlike chaplains who have not been trained or certified, are in the perfect position to provide this resource due to their access to the scene and ability to remain religion neutral. However, chaplains providing care may be passed over as a resource because management in many public safety agencies are afraid, or do not understand how to use chaplains when a traumatic event occurs. Additionally, agencies may steer away from chaplains because of the perceived connection with a religion.

The author has served as a Virginia State Trooper for 26 years and in 20 of those years, has also performed additional roles as a chaplain and coordinating the state's CISM team at the April 16, 2007, Virginia Tech massacre. CISM and PFA have components to train and utilize chaplains as a resource; however, from his own experiences in the numerous traumatic events to which he has responded, managing authorities of a critical incident do not frequently call upon chaplains to get involved. The author currently does not have empirical data to identify managing authorities not utilizing chaplains in a crisis; however, he has witnessed it many times, and when speaking with other chaplains from other organizations, hears the same argument.

The primary argument for management failing to incorporate chaplains as a critical component to crisis interventions is the connection with religion; that is, the fear that the "separation of church and state" will be violated. Stakeholders in crisis interventions will need to address this concern and examine the evidence.

Stakeholders, first responder organizations, and the community will need to be educated regarding the concept of "church and state" and persuade all audiences that unconstitutional situations will not be supported. In today's culture, religion has taken on a negative tone and governments may use "separation of church and state" as a reason to refrain from employing chaplains in PTSD policies. The First Amendment to the Constitution states, "Congress shall make no law respecting an establishment of religion, or prohibiting the establishment thereof."[218] The term "separation of church and state" appears in no founding document. U.S. Congressional records show the debate on the First Amendment from June 7–September 25, 1789, and the debate clearly shows the intent of the First Amendment in two specific areas.

1. Prohibited the United States from having a national denomination from running the nation, which is known as the "Establishment Clause." In part, it says: "Congress shall make no law respecting the establishment of religion…."[219]

2. Prohibits the federal government from interfering with, or limiting, the people's religious expression, which is known as the "Free Exercise Clause." In part, this says "….or prohibiting the free exercise thereof."[220]

The term "separation of church and state" came from a letter written by Thomas Jefferson to the Danbury Baptist of Connecticut on November 7, 1801. Thomas Jefferson stated, "there is a wall of separation between church and state." This wall would prevent the government from interfering with or hindering religious activities.[221] It seems that the modern interpretation of Thomas Jefferson's letter is the exact opposite of his intent. Now it seems that religious expression cannot be present in the affairs of state, schools, etc. It is important to note that the United States still utilizes chaplains in the U.S. Senate, the House

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[218] The Declaration of Independence and the Constitution of the United States, U.S. Government Printing Office 2008, 33.

[219] Ibid.

[220] Ibid.

[221] Thomas Jefferson, *The Writings of Thomas Jefferson*, vol. XVI, ed. Albert E. Bergh (Washington, DC: The Thomas Jefferson Memorial Association of the United States, 1904), 281–282.

of Representatives, and the military. Additionally, "In God We Trust" is still applicable today and is found in the U.S. National Anthem, Pledge of Allegiance, and is printed on U.S. currency.

In contrast, many courts and organizations like the American Civil Liberties Union (ACLU) are opposed to any government activity connected to religion. One argument made is that "once government becomes involved in religion and acquires the power to promote religious beliefs, it also acquires the power to suppress them."[222] In 1947, *Everson v. Board of Education*, the United States Supreme Court proclaimed "the wall between the separation of church and state should remain high and impregnable and we should not approve the slightest breach."[223] The United States Supreme Court ruled in *Engel v. Vitale* and *School District of Abington Township v. Schemp,* that prayer and bible reading should be removed from public schools. The ACLU cited that children whose religious beliefs are different from the majority must not be made to feel like outsiders in their schools, nor must religious participation be forced upon them.[224] Currently, the United States has more than 1,500 different religious bodies and sects.[225] In other actions, the ACLU has fought to remove religious symbols from the public square, such as the Ten Commandments, and Christmas symbols.[226]

Does incorporating chaplains breech the wall of separation of church and state as established by the constitution? The author suggests they do not and are already employed in government institutions, such as Congress and the military. This topic is discussed in greater detail in Chapter V. Currently, most chaplains receive training to minister to people associated with any religion, as

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[222] "From the Lectric Law Library's Stacks ACLU Briefing Paper Number 3—Church and State," *The Lectric Law Library* (n.d.), http://www.lectlaw.com/files/con07.htm.

[223] "ACLU Briefing Paper: Church and State," *American Civil Liberties Union*, (n.d.), http://www.aclu.org/FilesPDFs/church_state99.pdf.

[224] Ibid.

[225] Ibid.

[226] Ibid.

well as individuals who have no religion. Chaplains are trained not to promote a national or state religion and should always remain religion neutral.

For example, in "Disaster Spiritual Care: Practical Clergy Responses to Community, Regional, and National Tragedy," a chaplain's function is articulated as a spiritual support and comforter for a broad number of individuals representing many faith traditions and cultures. At a mass causality incident, many faiths and denominations are represented and some have no religious beliefs at all. As a result, chaplains are trained not to preach or proselytize their own specific faith tradition.[227]

Another limitation that may impede the utilization of chaplains at a crisis is that chaplains and clergy are viewed as "one in the same." Major differences exist between a chaplain and a pastor, minister or priest. Chaplain duties are nondenominational whereas a minister may represent a particular faith or tradition. Chaplain duties are performed without regard to the religion of the person being helped, which is very different for a minister, for whom the focus would specifically be on the religious traditions of the particular religion.[228]

Furthermore, many ministers and even some chaplains do not have training in disaster care. As a result of inadequate training, some ministers and chaplains may unintentionally provide inappropriate care, become a hindrance to rescue efforts, and not be safe at the scene of a crisis. Thus, another problem is often exposed in which many ministers, and some who identify themselves as a chaplain, self-dispatch themselves to a traumatic event. A prime example was discovered in the aftermath of 9/11 and at the Virginia Tech Massacre.

On 9/11, after the World Trade Centers were struck and later collapsed, many individual clergy members self-dispatched to sites that may have needed assistance. Some went to ground zero, while others went to the hospitals or to

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[227] Davidowitz-Farkas and Hutchison-Hall, "Religious Care in Coping with Terrorism," 565–576.

[228] Weiss and Davis, "Establishing a Chaplaincy Program," 81–86.

the community at large. Some were found confusing proselytization with disaster ministry.[229] To get a handle on this situation, the national "Spiritual Care Aviation Incident Response Team" (SAIR),of the American Red Cross was mobilized and formed a structure to screen, credential, deploy, schedule shifts, and "defuse" chaplains when the shift was over. Clergy were expected to be endorsed by a faith community, have one unit of Clinical Pastoral Education, and three years post-seminary experience.[230] Some chaplains and ministers were ineligible to assist, and thus, were not allowed access to the crisis scene. The SAIR Team of the American Red Cross provided organization on a large scale that mitigated those who self-dispatched.[231]

At the Virginia Tech Massacre, the Virginia State Police dispatched the author as a chaplain. He was in charge of taking care of the family members of the deceased, which involved delivering numerous death messages to family members. A safe place was provided for the families that allowed the families to be shielded from the press and self-dispatching clergy who came from all across the United States. Although many of the clergy had good intentions, some came with the intention to proselytize their own belief system. The author recalls an argument in one of the hallways between two different religious groups. The argument was about which religion had the right beliefs, which is the last thing a grieving family needed to hear, and fortunately, did not. This type of behavior is focused more on self and traditions than providing care for the traumatized. Such scenes may cause management in agencies to question the necessity of chaplains at a crisis.

Training in disaster care, as well as controlling access, is the best practice when chaplains administer PFA at a disaster. At Virginia Tech, the controlled access established and the utilization of trained chaplains were instrumental in

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[229] Storm Swain, "The T. Mort. Chaplaincy at Ground Zero: Presence and Privilege on Holy Ground." *J Relig Health* (August 18, 2011): 483.

[230] Ibid.

[231] Ibid.

providing care and protection for these families. Even though many of the families were from different faiths and traditions, the chaplains were able to meet them emotionally and spiritually.

F.   CONCLUSION

From the author's own experiences, chaplains have not been viewed as a valuable resource in crisis management; however, due to evidence showing that a majority of individuals turn to prayer, religion, or spiritual feelings in the wake of a disaster, trained chaplains can be a valuable resource. Primarily, this observation occurs because chaplains are typically viewed as a trusted confidante and are trained in religious coping mechanisms, as well as providing non-religious coping mechanisms at a disaster.

In part, because victims believe they will be cared for, chaplains are effective in crisis interventions. Belief is a powerful medicine that can have power over the mind to recover from a traumatic event. Faith means believing in something. The faith that a chaplain intervention will help becomes a placebo effect, and a form of healing. The placebo effect can be understood as faith healing caused by beliefs of providers and victims that intervention will work to make them better.[232] "The fact that placebo's can activate pathways of healing underscores their importance for therapeutics."[233]

In contrast, the role of a chaplain is diminished by the placebo effect if the victim of a crisis has a lack of faith in the help being offered. Additionally, chaplains may be associated with a particular religion or tradition in which the victim does not believe. Chaplains should be responsive to victim's feelings, good or bad, and adjust accordingly. Understanding the placebo effect and the bias of a victim can help identify the best approach.

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[232] Miller, "Williams James, Faith, and The Placebo Effect," 273–281.

[233] Kradin, "The Placebo Response," 328–338.

To overcome the barriers that sometimes prohibit chaplains from being readily available, and not being fully integrated into crisis intervention policies, it will be necessary to educate all stakeholders on the role and training of a chaplain. Education and collaboration can help resolve many concerns as "Best Practices" are sought to care for the traumatized.

> Collaborative processes create new knowledge and unanticipated policies and practices. They can result in changes in the values, goals, shared understandings, and underlying attitudes of the participants. Such changes in turn enhance the capacity of both individuals and the group as a whole to approach action in contingent ways, recognizing that the world might not turn out to be as they imagine it.[234]

The next chapter provides a recommendation on the best approach to crisis interventions, the potential barriers that need to be addressed, and a plan on how to integrate the best approach into a crisis intervention policy.

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[234] David E. Booher and Judith E. Innes, *Planning with Complexity: An Introduction to Collaborative Rationality for Public Policy* (New York: Taylor & Francis, 2010), Kindle edition, 34.

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V.   RECOMMENDATIONS AND CONCLUSIONS

A.   INTRODUCTION

In the examination and analysis of research on traumatic incidents, the author has examined how first responders often confront stressful events, ranging from death and mass causalities to destruction of property and terrorism. The stresses incurred by first responders may result in PTSD or Acute Stress Disorders (ASD), which potentially disrupt the first responders' ability to function at home and or in the work place.

Why should anyone care? The answer to this question is found in the responsibilities and tasks first responders have. In simplistic terms, first responders "protect and serve." They maintain order, prevent chaos, and keep everyone safe and secure. Much of the freedoms enjoyed today are the result of first responders protecting and caring for U.S. citizens. Whether it is a terrorists attack, a criminal victimizing a citizen, or a natural disaster, first responders will be one of the first on the scene to deal with the crisis. For this reason, their role in homeland security is so critical. As articulated in the research, traumatic stress experienced by first responders may impact their ability to function and handle the next critical incident, as well as obstruct public safety agencies in maintaining a robust and resilient workforce. Therefore, it is important to create an effective crisis intervention technique to help first responders mitigate stress following a traumatic incident.

Research on current crisis intervention techniques reveals that CISM is the standard clinical practice most widely utilized by public safety agencies in crisis interventions. CISM is designed to mitigate stress and PTSD. Another technique to help the traumatized, now emerging as a preferred response in crisis interventions, is PFA. The empirical evidence was examined comparing

CISM and PFA in an attempt to determine the best care for first responders. Another valuable tool examined, and sometimes overlooked as a crisis intervention tool, is the role of chaplains in a crisis.

B. RECOMMENDATIONS

Through analysis of the research, examination of the data, and the author's personal experiences, he has concluded, that in the majority of CISM interventions, CISM is not the best method to help victims of trauma and, in some cases, may be harmful to first responders. Some studies reflect that individuals who received no intervention compared with those who received non-CISM interventions actually fared better than those who received CISM interventions. Additionally, researchers found that CISD did not improve natural recovery with respect to other trauma-related disorders.[235]

A better approach to crisis intervention is the utilization of psychological first aid. This method provides comfort in a social context involving family, friends, co-workers, and trained chaplains or clergy. The author has witnessed positive results when PFA is provided at the scene of a traumatic incident, while the incident is still on going. The earlier a provider can identify the first responder's stress and emotional state, the better the outcome. The first responders can be consoled and comforted immediately, unlike CISM that provides support after a traumatic incident is over.

Although little research has been conducted on the efficacy of PFA, it could prove to be a useful tool when coupled with chaplains. The possibility of a unified response team could prove to be an invaluable tool for all types of traumatic incidents, since all levels of trauma could be addressed with a one-team approach.

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[235] Bledsoe, "Myth 3: Critical Incident Stress Management (CISM) Is Effective in Managing EMS-Related Stress," 2.

The author has been a first responder for 26 years and a chaplain for 20 years. He has personally been involved in numerous traumatic incidents. He has witnessed and participated in CISM interventions, and provided PFA as a chaplain during and after a traumatic incident. These experiences have provided him theoretical sensitivity, and thus, facilitated insight into crisis interventions by having the ability to give meaning to data, the capacity to understand it, and facility to separate pertinent facts from non-pertinent facts. Considering his personal experiences and the research pointing to the efficacy of incorporating religious coping mechanisms, he recommends chaplains be incorporated into PFA interventions. PFA utilizing chaplains, at the very beginning of a traumatic incident, would benefit first responders, agencies, and ultimately, the homeland security mission. The benefits are primarily due to the training chaplains can receive in disaster spiritual care. Chaplains are often viewed as someone who can be trusted, maintain confidentiality, and someone who has a connection with faith and religion.

> It is clear that spirituality, religion, and faith-based communities can play a key role in coping with the trauma of a terrorist attack. Although the mental health profession has historically neglected these resources, the recognition of their importance for mental health services is emerging. A nation locked in combat with terrorism cannot afford to overlook such a resource.[236]

C.   LIMITATIONS TO CHANGING CRISIS INTERVENTION METHODS

Changing intervention methods in crisis interventions will require first responder organizations to adapt new policies and promote new agendas to treat first responders in traumatic incidents; however, changing policies in any organization can be problematic. Some of the potential roadblocks may include the following.

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[236] Kelly, "The Role of Religion, Spirituality, and Faith-Based Community in Coping With Acts of Terrorism," 137–152.

- Why change? It has always be done this way.
- How much does it cost?
- What will be required for training?
- If incorporating chaplains, will the "separation of church and state" be violated?
- Will anyone be offended?
- Will organizations, such as the ACLU, be opposed to policies incorporating religious coping mechanisms?

The strategy to keep or change current crisis intervention policies should begin with bringing all of the stakeholders together. Stakeholders should include individuals who are for and against a particular crisis intervention technique. Additionally, leaders of public safety agencies, first responders affected by traumatic events, chaplains, mental health personnel, or any other entity mutually agreed upon should be at the table. Once together, all stakeholders should effectively collaborate with one another sharing ideas, wants, concerns, etc…

> All the affected interests jointly engage in face to face dialogue, bringing their various perspectives to the table to deliberate on the problems they face together. For the process to be collaboratively rational, all participants must also be fully informed and able to express their views and be listened to, whether they are powerful or not. Techniques must be used to mutually assure the legitimacy, comprehensibility, sincerity, and accuracy of what they say. Nothing can be off the table. They have to seek consensus.[237]

When addressing the potential roadblocks and changing a groups agenda, stakeholders' ideas need to be articulated and examined by each stakeholder. In addressing the potential roadblocks, the following ideas could be on the table for stakeholders to consider.

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[237] Booher and Innes, *Planning with Complexity: An Introduction to Collaborative Rationality for Public Policy*, 6.

1.   Why Change? It Has Always Been Done This Way

Provide evidence through studies and meta-analysis pointing to the successes and failures of CISM, PFA, and incorporating chaplains into crisis intervention policies. For example, many studies have identified CISM as ineffective and sometimes harmful to first responders. Many public safety agencies have discontinued CISM as a crisis intervention method. PFA has emerged as an alternate approach as "experience in the field suggests that it will be acceptable to and well received by consumers."[238] In regards to chaplains, voluminous literature and historical evidence exists concerning the successful role of chaplains. Many controlled trials and studies have concluded that religious therapy resulted in significantly faster recovery from depression when compared with standard behavioral therapy.[239]

Additionally, the significance of incorporating spirituality in the wake of a disaster was discovered in a national poll conducted by the American Red Cross one month following the 9/11 terrorist attacks. Results of the poll showed approximately 60% of all survivors said they would likely seek help from a spiritual counselor, compared to 45% of all respondents who would seek help from a physician and 40% who would seek help from a mental health care professional.[240] Also, statistics claim 97% of Americans believe in God and 90% pray. It is not surprising that people turn to their faith or spiritual roots when experiencing crisis or stress.[241]

Change can be difficult and hard for many. Pointing to the successes and failures, as well as listening to all ideas from the stakeholders, can help facilitate change and offer hope for the future.

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[238] Ruzek et al., "Psychological First Aid," 4.

[239] Propst, "Comparative Efficacy of Religious and Nonreligious Cognitive-Behavioral Therapy for the Treatment of Clinical Depression in Religious Individuals," 94–103.

[240] Davidowitz-Farkas and Hutchison-Hall, "Religious Care in Coping with Terrorism," 565–576.

[241] Taylor, "Spiritual First Aid," 106–118.

2. How Much Does It Cost?

CISM and PFA are marketed as a cost effective approach to crisis intervention. Stakeholders would need to evaluate a cost analysis of crisis intervention methods to include chaplains that should also include the cost of changing from one crisis intervention method to another. Currently, many first responder organizations already have chaplains on staff and many are volunteers, which helps to mitigate costs.

3. What Will Be Required for Training?

Stakeholders need to evaluate training based on proven methods for crisis interventions. Stakeholders must determine which technique is most effective for first responders. CISM and PFA provide training opportunities through conferences, seminars, and through online learning websites. Opportunities are also available to train a trainer within an agency, which allows them to train employees within the organization and mitigate training costs.

4. If Incorporating Chaplains, Will the "Separation of Church And State" Be Violated?

Stakeholders need to address this concern and examine the evidence. Stakeholders, first responder organizations, and the community must be educated regarding the concept of "church and state" and persuade all audiences that unconstitutional situations will not be supported.

If the stakeholders consider incorporating chaplains at the very beginning of a traumatic incident, standardized training for disaster spiritual care needs to be developed. Currently, chaplains receive training to minister to people associated with any religion, as well as individuals who have no religion. Chaplains are trained not to promote a national or state religion and should always remain religion neutral.

To help mitigate a possible culture war in which chaplains would be viewed by some as pushing religion, the author thinks it is critical that any opposition should be at the table of negotiations to collaborate before finalizing any new crisis intervention policy.

Furthermore, a frequent misconception is that the roles of chaplains and pastors are the same. On the contrary, several differences make chaplains an excellent choice for being used in PFA. Chaplains serve the community and people of all faiths. A pastor or minister is inwardly focused on a particular faith or denomination. The government recognizes an ordained chaplain, whereas an ordained pastor or minister is not because of the separation of the church and state issue. A chaplain's ministry serves as a bridge between the secular and the sacred. The Constitution of the United States provides the means for this to be accomplished.[242] The following examples from Living Shield Ministries are provided.

The Supreme Court in *Lemon vs. Kurtzman* (403, U.S. 602, 1971) used a three-pronged test that interpreted the constitutionality of ministries or church related services that may be questioned in relation to church and state issues. The establishment clause states, "Congress shall make <u>no law</u> respecting the <u>establishment of religion</u>, or <u>prohibiting</u> the <u>free exercise thereof</u>; or abridging the freedom of speech, or of the press, or the right of the people peaceably to assemble to petition the government for a redress of grievance."[243] Chaplaincy is not an offense to the establishment clause of the First Amendment and is validated by the Constitution as follows.

- "It has a "secular" purpose. A chaplain's primary purpose is secular (crisis intervention) followed with strong spiritual overtones. The Supreme Court has explained that there can be no animus of religion (animosity against religion) in the design and goal of the program. However, the court has also made it clear that the

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[242] Steve Ballinger, *Living Shield Ministries*, 2012, www.livingshield.org/index.php?option=com_content&view=article&id=53&Itemid=58 (accessed July 6, 2012).

[243] Ibid.

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presence of religious purpose, being secondary, would not change any established laws and how they are interpreted and practiced. The court will not validate any legislations or governmental action when a secular purpose is lacking, but it will validate the action if it is proven that the activity is motivated wholly by religious consideration."[244]

- "In Carter vs. Broadlawns Medical Center, a case challenging a hospital chaplaincy program, the 8th Circuit Court of Appeals held that the district court pliancy erred by focusing almost exclusively on the religious purpose, without looking at the complete subject matter, which reveals a valid secular purpose (to help patients get well). Thus, as long as there is a valid Secular Purpose, there may be religious benefits to the program without violating the Constitution."[245]

- "The government action must not have the primary or principle effect of enhancing or inhibiting religion. In other words, the government must remain neutral on all matters concerning relief organizations and their involvement in government and/or its agencies. Its principle effect must be one that neither advances nor inhibits religion. Just because a program that is run by a religious organization involved in government and its agencies receives an incidental benefit under government policy does not mean it has violated the primary effect."[246]

  - "In Carter vs. Broadlawns, the hospital chaplaincy program was challenged on the grounds that it violated the effect test by providing financial aid to enable persons in its care to practice their religions. While the district court concluded that paying a chaplain to provide religious care is an advancement of religion, the 8th Circuit Court of Appeals noted that some financial benefit to religion can be tolerated in applying the effect of the element."[247]

  - "Government or its agencies can hire (pay) chaplains to perform their services. However, the religious selection result must be done through a religiously neutral process rather than a specific church or religious organization that would restrict the eligibility of the chaplains."[248]

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[244] Ballinger, *Living Shield Ministries.*

[245] Ibid.

[246] Ibid.

[247] Ibid.

[248] Ibid.

- "The final action is that the government must not foster an excessive entanglement with religion. The agency cannot enforce exclusion of certain religious guidelines but must open its forum to all religious doctrines. Nor can the government oversee, inquire, determine or monitor the religious material (what is religious and what is not) and religious doctrine, for it would violate the undue entanglement element. At the same time."[249]

An analysis of the above information reflects that chaplaincy complies with the three-pronged test. Thus, as a result, the military, Congress, schools, hospitals, Department of Corrections, and public safety agencies currently have chaplaincy programs.

5. Will Anyone Be Offended?

Currently, CISM is the most widely used crisis intervention technique to mitigate stress and prevent PTSD in first responders. If CISM is discontinued, and another crisis intervention technique employed, supporters of the CISM process will be reluctant to change. The same applies to PFA and incorporating chaplains in crisis intervention policies, which underscores the importance of having all stakeholders present at the table and having face-to-face dialogue to negotiate their concerns. Stakeholders should include individuals who are for or against a particular crisis intervention technique. Through collaboration, stakeholders could discuss what parts they support of CISM and whether it is beneficial to keep some of the CISM components. One common goal for all stakeholders should be to develop an effective policy that will care for responders following a traumatic incident, and as such, would be a good place to start the discussion.

6. Will Organizations Such As the ACLU Be Opposed to Policies Incorporating Religious Coping Mechanisms?

Historically, agencies, such as the ACLU, have been opposed to any practice that may infringe on the "separation of church and state." Changing any

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[249] Ballinger, *Living Shield Ministries.*

policy that incorporates spirituality may disrupt their agenda. All stakeholders should consider their views and any supporting evidence. Additionally, a legal representative should evaluate rewritten policies prior to approval. The ACLU or any other opposing entity should be at the table.

D. EVALUATION

Although little research or randomized clinical trials have been conducted in the area of psychological first aid, providing evidence and measuring the impact of survivor adaption and functioning could measure the effectiveness of psychological first aid following a traumatic event.[250] A traumatic response team could incorporate other facets of the mitigation process, and comprise a traumatic response team of trained psychological first aid providers to include fully trained chaplains trained in disaster spiritual care to enable a team to personalize the coping process. As observed following 9/11, the Red Cross conducted a study that reflected 59% of the Americans polled would seek help from a spiritual counselor as opposed to only 40% would seek help from a mental health professional.[251] More evidence-based research is needed on the effectiveness of chaplains providing care at a disaster; however, the utilization of chaplains in hospitals, the military, correctional facilities, and public safety agencies have proven to be effective. The following are some examples.

- A 30-month study of 700 cardiac patients at a Veterans Affairs Hospital was completed. Patients receiving daily chaplain visits compared to patients who did not receive daily chaplain visits went home three days earlier. The estimate of savings was $4,000 per patient.[252]

- When chaplains help a patient's family, it tends to cope better with hospitalization.[253]

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[250] Ruzek et al., "Psychological First Aid," 10.

[251] Taylor, "Spiritual First Aid," 106–118.

[252] Terese Hudson, "Measuring the Results of Faith." *Hospitals & Health Networks*, no. 18 (1996): 22–4, 26–8.

[253] Healthcare Chaplain Ministry Association, "Value of an HCMA Chaplain," 2007, http://www.hcmachaplains.org/files/Value%20of%20a%20Chaplain.pdf.

- Staff retention and productivity is improved. One study reflects that 73% of intensive care physicians and nurses believe that providing comfort to staff is an important role of a chaplain, and 32% believe chaplains should be available to help staff with personal problems.[254]

- Health care facilities incorporating chaplains report that their services are cost efficient ranging from $2.71 and $6.43 per patient visit.[255]

- The Supreme Court has ruled that a "compelling public interest" is served by hiring chaplains to serve the religious needs of the members in the armed forces.[256]

- The military is recruiting more chaplains due to inadequate staffing levels.[257]

- The State of California, Department of Corrections, has a chaplain-to-inmate staffing ratio of 1 to 1,300. This ratio is the highest in the country. Due to the effectiveness of the chaplaincy program and the analysis of a comparative study, the ratio now recommended is a 1 to 500 ratio.[258]

- In a report submitted to the U.S. Department of Justice on East Lansing Police's Chaplain Program, a survey on the effectiveness of the chaplaincy program revealed 82% of employees would seek the services of a chaplain when confronting stress.[259]

With the efficacy reported in the above examples, and the need for chaplains articulated in other chaplain services, it is hypothesized that chaplains providing disaster spiritual care would also be effective and enhance crisis management teams.

Abraham Maslow identified basic physical and psychological needs, and certainly, is a good place to start when examining how to best deliver and measure the success providing comfort through PFA principles. However, an

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[254] Healthcare Chaplain Ministry Association, "Value of an HCMA Chaplain."

[255] Ibid.

[256] State of California, Department of Corrections, "Chaplain Staffing Study," 1991, 7.

[257] Andrea Stone, "Military Cope with Shortage of Chaplains." *USA Today*, February 5, 2008, 1–5.

[258] State of California, Department of Corrections, "Chaplain Staffing Study," 54.

[259] East Lansing Police Department, East Lansing Police Chaplain's Program, 5.

evidence-based approach to crisis interventions is necessary to prove its efficacy.[260] The PFA guide does include evaluation measures that can be used to evaluate the types of issues and concerns experienced by survivors. Additionally, the National Child Traumatic Stress Network, Terrorism and Disaster Working Committee has formed a sub-committee to assess how PFA is being used and to what effect.[261]

E.   CONCLUSION

What is the best approach to crisis interventions? Analysis of the research indicates that utilizing CISM as a stand-alone practice in crisis interventions is problematic. Some research identifies CISM as a successful cost effective practice to mitigate PTSD. Other research portrays CISM as ineffective and harmful to first responders and public safety agencies when confronting PTSD. The time of intervention in the CISM model is also a concern. While every effort should be made to provide necessary care for first responders, decision makers of public safety agencies also need to know what course of action is best.

PFA is emerging as the more appropriate method when confronting first responders involved in a traumatic incident. As a chaplain, the author has witnessed the success of this approach. Through a comparative policy analysis between CISM and PFA, and his personal experiences as a first responder and chaplain, he has concluded that PFA will emerge as the better approach to crisis interventions; however, further research, empirical evidence, and reporting mechanisms are needed to prove this theory. Also, social contacts, such as friends, co-workers, and clergy or chaplains, will be a critical component in the efficacy and delivery of PFA.

Although little formal research has been conducted in the area of PFA, it could prove to be a useful tool when coupled with chaplains. Chaplains bring a

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[260] Eric M. Vernburg et al., "Innovations in Disaster Mental Health: Psychological First Aid," *Professional Psychology: Research and Practice* (2008): 381–388.

[261] Ibid.

spiritual element to the table, have been proven effective in many institutions, and would enable a crisis management team to personalize the coping process. A PFA team would be capable of assisting the traumatized in varying degrees and the addition of the chaplain would enable healing on a religious and a non-religious level. The possibility of a unified response team could prove to be an invaluable tool for all types of traumatic incidents, since all levels of trauma could be addressed with a one-team approach.

It is important to recognize how important the men and women are who protect America and how important their skills and abilities are to the homeland security mission. In the author's opinion, all men and women involved in the protection of this country are part of the homeland security enterprise. If a traumatic incident affects their ability to perform, and policies are not in place to give them the support they need, these men and women will become ineffective. First responders will feel less valued and may consider legal action if care is not provided.

The desired outcome is for the first responders to receive care by having someone who will listen and help them find relief when battling stress, PTSD, or ASD, as well as public safety agencies maintaining a resilient work force. The author believes PFA and trained chaplains in disaster spiritual care can be instrumental in achieving this outcome.

F.   MOVING FORWARD

The author recommends public safety agencies conduct further research into the possibilities of incorporating PFA. The methodology recommended to research and develop a PFA policy may include the following.

- Specifying the PFA Intervention Model—Define core principles and techniques for PFA in a manual format. Develop a field operation guide for PFA providers with clear guidelines. Assess if PFA providers are able to utilize their skills in preparedness drills and training exercises and offer a set of skills that can be measured

systematically. Conduct studies of the actions provided by PFA providers through records generated when providing PFA.[262]

- Specifying Outcomes—Recall that the purpose of PFA is to reduce initial distress caused by traumatic events and foster short-term and long-term adaptive functioning of survivors. Outcomes should be measured and could be assessed by utilizing self-reports of survivors soon after PFA is delivered. Survivors could be asked to describe or rate their experience after receiving PFA.[263]

- Clarify Evaluation Design Issues—It would be difficult to conduct a randomized controlled trial on PFA but measuring types of mental health interventions offered in the first few days and weeks is more feasible. Match components of PFA with the survivor's most immediate needs and circumstances. A written record of survivor's immediate needs and PFA provider's actions and recommendations is necessary.[264]

Research on the efficacy when incorporating chaplains needs to continue and be expanded. Before chaplains are utilized, training needs to be examined, validated and standardized. The "do's and don'ts" when providing PFA and incorporating religious coping mechanisms need to be reviewed. Additionally, examination of successes and failures associated with chaplains when involved in traumatic incidents is necessary. The author has witnessed many traumatic incidents in which chaplains were involved and the first responder was able to function, complete the assignment, and return to work with little to no interruption. He would measure the success of chaplaincy through interviews and studies of first responders receiving the services of a chaplain, as well as first responders who had not received the services of a chaplain.

Another evaluation mechanism that stakeholders can develop is to create a survey for first responders and victims of a tragedy. This survey could include questions on what works best in crisis interventions. Once the survey is completed, stakeholders would examine and evaluate the responses as part of creating an effective crisis intervention policy. This process could also be used as

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[262] Ruzek et al., "Psychological First Aid," 12.

[263] Ibid.

[264] Ibid., 13.

a tool to evaluate a new policy developed by the stakeholders to allow any new plan to learn, adapt, or improve. The survey could be completed using technology so that aggregating data could be completed quickly and accurately, and thus, allow the results to be shared readily through raw data spreadsheets, charts, and tables. Data would be gathered and findings would be submitted to decision makers.

The author has responded to numerous traumatic incidents and witnessed first-hand the effects trauma has on first responders. As a result of witnessing the lack of care CISM provides, he was inspired to research and find the best approach to crisis interventions. PFA with trained chaplains in disaster care can provide the necessary care first responders need and deserve.

PFA and trained chaplains may be the answer; however, the author also desires that this paper inspire and challenge other agencies to invest, conduct further research, and ultimately, find the best approach to crisis interventions.

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